Tan Sri Datuk Seri Mohd Hussein bin Abd Hamid v Gleneagles Hospital (Kuala Lumpur) Sdn Bhd & Anor

COURT OF APPEAL (PUTRAJAYA) — CIVIL APPEAL NO W-02fNCVC)(W)-1000–06 OF 2022
KAMALUDIN MD SAID, SUPANG LIAN AND AZIMAH OMAR JJCA
20 JUNE 2024

Tort — Negligence — Medical negligence — Whether surgeon was negligent in injuring patient's popliteal artery whilst performing arthroscopy in the knee joint — Whether surgeon was negligent in failing to inform patient of risk of injury to the artery — Whether surgeon was independent contractor — Whether private hospital where surgeon practised was vicariously liable for surgeon's negligence — Whether hospital owed patient non-delegable duty of care

The instant appeal was against the High Court's dismissal of the appellant's medical negligence suit against the respondents. The appellant had claimed that the second respondent ('R2') — a consultant orthopaedic and trauma surgeon who had a private practice in a hospital owned and managed by the first respondent ('R1') — had negligently injured the popliteal artery located at the back of his right knee joint whilst performing an arthroscopy on the knee joint. The appellant alleged that R2 did not warn him beforehand that the procedure had the risk of injuring the popliteal artery. The claim against R1 was for vicarious liability for R2's negligence and also for breach of its non-delegable duty of care to the appellant. The arthroscopic debridement on the appellant's right knee was done to remove all or part of a torn meniscus, remove small loose fragments of cartilage and to address the damaged cartilage in the knee in order to lessen friction and pain in the knee. However, three days after the procedure and whilst still admitted in the hospital, the appellant saw a blue-black mark on his right knee and felt excruciating pain in the joint. Tests revealed a tear in the popliteal artery and surgery was promptly done to repair the damage. Despite the repair, the appellant complained of increased pain in the knee which curtailed his movements and activities. After a full trial, the High Court found the claim against R2 not proven and consequently dismissed the suit against both respondents without assessing damages. The trial court held that there was no failure on R2's part to sufficiently warn the appellant of the risks of the arthroscopy procedure and that the 'very rare' risk of popliteal artery damage 'was encompassed by the warning of risk of bleeding'. The trial court found that the opinions of R2's medical experts as to how the arterial injury could have occurred ('the avulsion injury theory') withstood logical analysis and was acceptable whereas the 'excessive force theory' advanced by the appellant's expert was not logical and acceptable. R2's experts opined that the injury was most likely caused when a branch of a blood

vessel had tugged on the popliteal artery whilst the arthroscopy procedure was being done. The excessive force theory, on the other hand, suggested that the injury was caused when instruments used in the arthroscopy procedure penetrated through the knee capsule (due to excessive force being used) and pierced the popliteal artery at the back of the knee — which theory was rejected as there was no evidence of extensive damage which would have occurred if such penetration had taken place. In the instant appeal against the High Court's decision, the appellant argued that: (a) R2 had never pleaded the avulsion injury theory in his statement of defence but had only raised it in the course of evidence at the trial; (b) R2 was negligent in failing to specifically advise the appellant of the risk of injury to the popliteal artery; (c) the trial judge failed to consider sufficiently, or at all, the evidence and the law regarding R1's non-delegable duty of care as well as its vicarious liability for R2's negligence; and (d) the trial judge's failure to make a decision on quantum was an error of law.

Held, by majority, allowing the appeal, setting aside the High Court's decision and remitting the case back to the trial court for assessment of damages:

(1) **(per Supang Lian JCA, majority)** Both parties to the suit had pleaded the nature of the injury that was suffered by the appellant during the arthroscopy but not as to how the injury could have occurred. On this issue, none of the parties had offended the rules of pleading as the material fact of the injury had been pleaded. The theories as to how the injury could have occurred were views that were required to be led through expert evidence and were not material facts that had to be pleaded (see paras 60–61).

(2) **(per Supang Lian JCA, majority)** The trial judge did not err in holding that the injury had occurred without any act of negligence. The assumption that carelessness alone was the reason for the injury could not be accepted and was devoid of logical deduction. The trial judge rightly found that the appellant had failed to prove that the injury was due to breach in the standard of care by R2 during the arthroscopy. The respondents did not breach the standard of care expected in diagnosis and treatment. The trial judge had taken into consideration all relevant evidence before holding that R2 was not negligent in performing the arthroscopy and had provided a plausible explanation, including by his experts, as to how the injury could have occurred. There was no reason for this court to disturb the finding of the trial judge (see paras 107 & 109–111).

(3) **(per Supang Lian JCA, majority)** The duty to advise of the risks associated with the surgery was specific in nature. R2 had failed to advise the appellant on the material risk of a popliteal artery injury. This was different from advising him of the risk of 'bleeding' during the surgery.

The trial judge erred in finding that the risk of a popliteal artery injury 'was encompassed by the warning of risk of bleeding'. Although R2's expert witnesses acknowledged that injury to the popliteal artery was an 'extremely rare' complication, it did not mean it was not a material risk. The risk must be informed to the patient if it was a material risk that the patient would likely attach significance to it or if the medical practitioner was, or should reasonably have been, aware that a particular patient, if warned of the risk, would likely attach significance to it. The appellant had testified that if he had been warned of the risk of injury to a 'vessel', he would not have undergone the arthroscopy (see paras 124 & 135–136).

(4) **(per Supang Lian JCA, majority)** By breaching his duty to advise the appellant of the risk of injury to the popliteal artery, R2 was negligent and had deprived the appellant of the chance to make an informed decision as to whether or not to proceed with the surgery. The appellant had therefore proven on balance of probabilities that R2 was liable in this medical negligence suit for his failure to advise the appellant on the material risks involved before the surgery was performed (see para 155).

(5) **(per Supang Lian JCA, majority)** There was insufficient evidence to show that R2 was 'truly' an independent contractor at R1's hospital. The hospital's terms and conditions of service were not sufficient and adequate notice to patients that the hospital was not responsible for the wrongs of its consultants. Therefore, the hospital was vicariously liable for R2's negligence (see para 165).

(6) **(per Supang Lian JCA, majority)** R1 had breached its non-delegable duty of care to the appellant. The five criteria identified in *Woodland v Essex County Council* [2014] 1 All ER 482 had been met in this case. The appellant was in a vulnerable position and was totally reliant on R1's hospital for its care and treatment. The appellant did not choose R2 to treat him but chose to seek treatment at R1's hospital and had an antecedent relationship with R1 before he was treated by and/or referred to R2. And when the first surgery went wrong, the procedures that were done and the doctors and personnel who were involved in repairing the injury to his popliteal artery were not of his choosing. Having assumed a positive duty of care to the appellant in respect of emergency services, R1 had delegated to the various doctors, including R2, the performance of its obligations to the appellant (see paras 173–181).

(7) **(per Supang Lian JCA, majority)** It was the bounden duty of the trial judge to decide on quantum notwithstanding the dismissal of the claim on liability. The case was therefore remitted back to the trial judge for assessment of damages (see paras 183–184).

(8) **(per Azimah Omar JCA, dissenting)** The appellant's argument that R2

had failed to plead the avulsion injury theory was baseless. Theories about how the injury might have occurred were matters of evidence to be adduced at trial. The appellant had similarly not pleaded its excessive force theory or how the injury had occurred but had only pleaded that his popliteal artery was 'pierced' (see paras 215–221).

(9) **(per Azimah Omar JCA, dissenting)** The trial judge correctly found that R2 had not gone below the standard of care expected of him in diagnosing and treating the appellant. The judge was entitled to prefer avulsion injury theory — and consequently hold that R2 had not been negligent in his treatment — as there was no evidence of extensive damage to support the excessive force theory. It was an accident that could have occurred even if there was no carelessness (see paras 229–232 & 244).

(10) **(per Azimah Omar JCA, dissenting)** R2's duty to warn or advice did not encompass warning or advising the appellant of the specific risk of avulsion injury to the popliteal artery as the risk of such an injury happening was sufficiently rare and unforeseeable. The rare and unforeseeable nature of the risk affected the materiality of that risk. It was unreasonable to expect a doctor to warn the patient about all and every conceivable risk inherent to every procedure. A risk might be immaterial if it was rare and unforeseeable or minimal (see paras 245 & 248–249).

(11) **(per Azimah Omar JCA, dissenting)** The facts and circumstances of the present case did not satisfy the five features of the *Woodland*'s test (chain of delegation): (a) the appellant was R2's patient first before he underwent the arthroscopy at R1's hospital; there was thus no antecedent relationship between the appellant and R1's hospital. Instead, there was an antecedent relationship directly between the appellant and R2; (b) R2 as the appellant's chosen surgeon had directly assumed positive responsibility to treat the appellant; (c) the appellant had full control and freedom to choose R2 to be his surgeon to undertake the arthroscopy; (d) R2 was not assigned or delegated with the assumed positive responsibility by R1's hospital; and (e) R2 had not been negligent. For these reasons, R1 had not breached its non-delegable duty of care to the appellant. The question of R1's vicarious liability did not arise as R2 was rightly found to be not negligent (see paras 261 & 283–284).

[Bahasa Malaysia summary

Rayuan semasa adalah terhadap keputusan Mahkamah Tinggi yang menolak tuntutan kecuaian perubatan perayu terhadap responden. Pihak perayu telah mendakwa bahawa responden kedua ('R2') — seorang perunding ortopedik dan pakar bedah trauma yang menjalankan amalan perubatan secara persendirian di sebuah hospital yang dimiliki dan diuruskan oleh responden pertama ('R1') — telah secara cuai mencederakan arteri popliteal yang terletak

di bahagian belakang sendi lutut kanannya semasa menjalankan prosedur artroskopi ke atas sendi lutut tersebut. Perayu mendakwa bahawa R2 tidak memberi amaran kepadanya terlebih dahulu bahawa prosedur itu mempunyai risiko mencederakan arteri popliteal. Tuntutan terhadap R1 adalah untuk liabiliti vikarius untuk kecuaian R2 dan juga untuk pelanggaran pelanggaran kewajipan jagaan tidak boleh diwakilkan terhadap perayu. Pembedahan debridement secara artroskopi ke atas lutut kanan perayu telah dilakukan bagi tujuan membuang keseluruhan atau sebahagian meniskus yang koyak, membuang serpihan rawan yang longgar, serta menangani kerosakan pada rawan lutut dengan tujuan untuk mengurangkan geseran dan kesakitan pada bahagian tersebut. Bagaimanapun, tiga hari selepas prosedur dan ketika masih dimasukkan ke hospital, perayu melihat kesan biru-hitam pada lutut kanannya dan berasa sakit yang amat sangat di bahagian sendi. Ujian mendedahkan koyakan pada arteri popliteal dan pembedahan segera dilakukan untuk membaiki kerosakan. Walaupun telah menjalankan pembaikan, perayu mengadu sakit lutut semakin meningkat yang menghalang pergerakan dan aktivitinya. Setelah perbicaraan penuh dijalankan, Mahkamah Tinggi mendapati bahawa tuntutan terhadap R2 tidak dibuktikan dan oleh itu menolak saman terhadap kedua-dua responden tanpa menilai ganti rugi. Mahkamah perbicaraan memutuskan bahawa tiada kegagalan daripada pihak R2 untuk memberi amaran yang secukupnya kepada perayu mengenai risiko prosedur artroskopi, dan bahawa risiko kerosakan arteri popliteal yang dikatakan 'amat jarang berlaku' itu telah diliputi dalam amaran mengenai risiko pendarahan. Mahkamah perbicaraan mendapati bahawa pendapat pakar perubatan R2 berkenaan bagaimana kecederaan arteri itu boleh berlaku ('teori kecederaan avulsi') adalah munasabah secara logik dan boleh diterima, manakala 'teori daya berlebihan' yang dikemukakan oleh pakar perayu adalah tidak munasabah dan tidak boleh diterima. Pakar R2 berpendapat bahawa kecederaan tersebut berkemungkinan besar berlaku apabila cabang salur darah tertarik pada arteri popliteal semasa prosedur artroskopi dijalankan. Teori daya berlebihan, sebaliknya, mencadangkan bahawa kecederaan itu disebabkan apabila instrumen yang digunakan dalam prosedur atroskopi menembusi kapsul lutut (disebabkan oleh daya yang berlebihan digunakan) dan menusuk arteri popliteal di bahagian belakang lutut — teori itu ditolak kerana tiada keterangan kerosakan yang meluas yang akan berlaku jika penembusan sedemikian telah berlaku. Dalam rayuan semasa terhadap keputusan Mahkamah Tinggi, perayu berhujah bahawa: (a) R2 tidak pernah membuat memplidkan terhadap teori kecederaan avulsi dalam pernyataan pembelaannya tetapi hanya membangkitkannya dalam semasa pengemukaan keterangan di perbicaraan; (b) R2 cuai kerana gagal menasihati perayu secara khusus tentang risiko kecederaan pada arteri popliteal; (c) hakim perbicaraan telah gagal untuk mempertimbangkan dengan secukupnya, atau langsung tidak mempertimbangkan, keterangan dan undang-undang berkenaan dengan kewajipan penjagaan yang tidak boleh diwakilkan oleh R1 serta liabiliti vikariusnya terhadap kecuaian R2; dan (d) kegagalan hakim perbicaraan untuk

membuat keputusan mengenai kuantum adalah kekhilafan undang-undang. A

Diputuskan, secara majoriti, membenarkan rayuan, mengetepikan keputusan Mahkamah Tinggi dan menyerahkan semula kes itu ke mahkamah perbicaraan untuk taksiran ganti rugi: B

(1) **(oleh Supang Lian HMR, majoriti)** Kedua-dua pihak dalam tindakan itu telah memplidkan jenis kecederaan yang dialami oleh perayu semasa atroskopi tetapi bukan tentang bagaimana kecederaan itu boleh berlaku. Mengenai isu ini, tiada mana-mana pihak telah melanggar peraturan pliding kerana fakta material kecederaan telah diplidkan. Teori tentang C bagaimana kecederaan itu boleh berlaku adalah pandangan yang perlu dibawa melalui keterangan saksi pakar dan bukan fakta material yang perlu diplid (lihat perenggan 60–61).

(2) **(oleh Supang Lian HMR, majoriti)** Hakim perbicaraan tidak terkhilaf D apabila berpendapat bahawa kecederaan itu berlaku tanpa sebarang tindakan kecuaian. Andaian bahawa kecuaian sahaja menjadi punca kecederaan itu tidak boleh diterima dan tiada logik. Hakim perbicaraan dengan betul memutuskan perayu telah gagal membuktikan bahawa kecederaan itu disebabkan oleh pelanggaran standard penjagaan oleh R2 E semasa atroskopi. Responden tidak melanggar standard penjagaan yang diharapkan dalam diagnosis dan rawatan. Hakim perbicaraan telah mengambil kira semua keterangan yang relevan sebelum berpendapat bahawa R2 tidak cuai dalam melakukan atroskopi dan telah memberikan penjelasan yang munasabah, termasuk oleh pakarnya, tentang F bagaimana kecederaan itu boleh berlaku. Tiada sebab untuk mahkamah ini mengganggu keputusan hakim perbicaraan (lihat perenggan 107 & 109–111).

(3) **(oleh Supang Lian HMR, majoriti)** Kewajipan untuk menasihati risiko G yang berkaitan dengan pembedahan adalah khusus. R2 telah gagal menasihati perayu tentang risiko material kecederaan arteri popliteal. Ini berbeza dengan menasihatinya tentang risiko 'pendarahan' semasa pembedahan. Hakim perbicaraan terkhilaf apabila mendapati bahawa risiko kecederaan arteri popliteal 'dirangkumi oleh amaran risiko H pendarahan'. Walaupun saksi pakar R2 mengakui bahawa kecederaan pada arteri popliteal adalah komplikasi 'amat jarang berlaku', ia tidak bermakna ia bukan risiko material. Risiko mesti dimaklumkan kepada pesakit jika ia merupakan risiko material yang mungkin akan dititikberatkan oleh pesakit atau jika pengamal perubatan itu, atau I sepatutnya secara munasabahnya, sedar bahawa pesakit tertentu, jika diberi amaran tentang risiko itu, berkemungkinan akan memberi kepentingan kepadanya. Perayu telah memberi keterangan bahawa jika dia telah diberi amaran tentang risiko kecederaan pada 'saluran', dia tidak akan menjalani artroskopi (lihat perenggan 124 & 135–136).

(4) **(oleh Supang Lian HMR, majoriti)** Dengan melanggar kewajipannya untuk menasihati perayu tentang risiko kecederaan pada arteri popliteal, R2 telah cuai dan telah melucutkan peluang perayu untuk membuat keputusan termaklum sama ada untuk meneruskan pembedahan atau tidak. Oleh itu perayu telah membuktikan berdasarkan imbangan kebarangkalian bahawa R2 bertanggungjawab dalam saman kecuaian perubatan ini kerana kegagalannya untuk menasihati perayu tentang risiko material yang terlibat sebelum pembedahan dijalankan (lihat perenggan 155).

(5) **(oleh Supang Lian HMR, majoriti)** Tiada keterangan yang mencukupi untuk menunjukkan bahawa R2 adalah 'benar-benar' kontraktor bebas di hospital R1. Terma dan syarat perkhidmatan hospital tidak mencukupi dan notis yang mencukupi kepada pesakit bahawa hospital tidak bertanggungjawab atas kesalahan perundingnya. Oleh itu, hospital bertanggungjawab secara vikarius atas kecuaian R2 (lihat perenggan 165).

(6) **(oleh Supang Lian HMR, majoriti)** R1 telah melanggar kewajipan penjagaannya yang tidak boleh diwakilkan kepada perayu. Lima kriteria yang dikenal pasti dalam *Woodland v Essex County Council* [2014] 1 All ER 482 telah dipenuhi dalam kes ini. Perayu berada dalam kedudukan yang terdedah dan bergantung sepenuhnya pada hospital R1 untuk penjagaan dan rawatannya. Perayu tidak memilih R2 untuk merawatnya tetapi memilih untuk mendapatkan rawatan di hospital R1 dan mempunyai hubungan anteseden dengan R1 sebelum dia dirawat oleh dan/atau dirujuk kepada R2. Dan apabila pembedahan pertama gagal, prosedur yang dilakukan dan doktor serta kakitangan yang terlibat dalam membaiki kecederaan pada arteri poplitealnya bukanlah pilihannya. Setelah memikul tanggungjawab positif untuk kewajipan penjagaan perayu berkenaan dengan perkhidmatan kecemasan, R1 telah mewakilkan pelaksanaan kewajipannya kepada beberapa orang doctor, termasuk R2 (lihat perenggan 173–181).

(7) **(oleh Supang Lian HMR, majoriti)** Ia adalah menjadi kewajipan terhad hakim perbicaraan untuk memutuskan kuantum walaupun tuntutan atas liabiliti ditolak. Oleh itu, kes itu dihantar semula kepada hakim perbicaraan untuk taksiran ganti rugi (lihat perenggan 183–184).

(8) **(oleh Azimah Omar HMR, menentang)** Hujah perayu bahawa R2 telah gagal untuk mengaku teori kecederaan avulsi adalah tidak berasas. Teori tentang bagaimana kecederaan itu mungkin berlaku adalah perkara keterangan yang perlu dikemukakan semasa perbicaraan. Perayu juga tidak memplidkan teori daya berlebihan atau bagaimana kecederaan itu berlaku tetapi hanya memplidkan bahawa arteri poplitealnya 'tertusuk' (lihat perenggan 215–221).

(9) **(oleh Azimah Omar HMR, menentang)** Hakim perbicaraan dengan betul mendapati bahawa R2 tidak berada di bawah standard penjagaan yang diharapkan daripadanya dalam mendiagnosis dan merawat perayu. Hakim berhak memilih teori kecederaan avulsi — dan memutuskan bahawa R2 tidak cuai dalam rawatannya — kerana tidak ada keterangan kecederaan teruk untuk menyokong teori daya berlebihan. Ia adalah satu kemalangan yang boleh berlaku walaupun tidak ada kecuaian (lihat perenggan 229–232 & 244).

(10) **(oleh Azimah Omar HMR, menentang)** Kewajipan R2 untuk memberi amaran atau nasihat tidak merangkumi amaran atau menasihati perayu tentang risiko khusus kecederaan avulsi pada arteri popliteal kerana risiko kecederaan sedemikian berlaku cukup jarang dan tidak dapat dijangka. Sifat risiko yang jarang berlaku dan tidak dapat dijangka menjejaskan kebendaan risiko tersebut. Ia adalah tidak munasabah untuk mengharapkan doktor memberi amaran kepada pesakit tentang semua dan setiap risiko yang boleh difikirkan yang wujud pada setiap prosedur. Sesuatu risiko mungkin tidak penting jika ia jarang berlaku dan tidak dapat dijangka atau minimum (lihat perenggan 245 & 248–249).

(11) **(oleh Azimah Omar HMR, menentang)** Fakta dan keadaan kes ini tidak memenuhi lima ciri ujian *Woodland* (rantaian perwakilan): (a) perayu adalah pesakit R2 terlebih dahulu sebelum dia menjalani atroskopi di hospital R1; Oleh itu, tiada hubungan anteseden antara perayu dan hospital R1. Sebaliknya, terdapat hubungan anteseden secara langsung antara perayu dan R2; (b) R2 kerana pakar bedah yang dipilih perayu secara langsung telah memikul tanggungjawab positif untuk merawat perayu; (c) perayu mempunyai kawalan penuh dan kebebasan untuk memilih R2 sebagai pakar bedahnya untuk menjalankan artroskopi; (d) R2 tidak diberikan atau didelegasikan dengan tanggungjawab positif yang dianggap telah wujud oleh hospital R1; dan (e) R2 tidak cuai. Atas alasan-alasan tersebut, R1 tidak telah melanggar kewajipan penjagaan tidak boleh diwakilkan (*non-delegable duty of care*) terhadap perayu. Persoalan mengenai liabiliti vikarius R1 tidak timbul memandangkan R2 telah didapati dengan sewajarnya tidak cuai (lihat perenggan 261 & 283–284).]

Cases referred to

Bolam v Friern Hospital Management Committee [1957] 1 WLR 582, QBD (refd)

Bolitho v City and Hackney Health Authority [1997] 4 All ER 771, HL (refd)

Browne v Dunn (1893) 6 R 67, HL (distd)

Christou v King Edward Memorial and Princess Margaret Hospitals Board of Management [2007] WADC 44 (refd)

Dato' Gopal Sri Ram v Dato' C Vijaya Kumar & Ors [2006] 6 MLJ 328, HC (refd)

Dr Hari Krishnan & Anor v Megat Noor Ishak bin Megat Ibrahim & Anor and another appeal [2018] 3 MLJ 281, FC (refd)
Dr Ismail Abdullah v Poh Hui Lin (administrator for the estate of Tan Amoi @ Ong Ah Mauy, deceased) [2009] 2 MLJ 599, HC (refd)
Dr Kok Choong Seng & Anor v Soo Cheng Lin and another appeal [2018] 1 MLJ 685, FC (refd)
Elizabeth Chin Yew Kim & Anor v Dato' Ong Gim Huat (sued as public officer of Hospital Lam Wah Ee) and other appeals [2017] 1 MLJ 328; [2017] 2 CLJ 274, CA (refd)
Emeh v Kensington and Chelsea and Westminster Area Health Authority and others [1979 E No 446] [1985] QB 1012, CA (refd)
Foo Fio Na v Dr Soo Fook Mun & Anor [2007] 1 MLJ 593, FC (refd)
Hepworth v Kerr [1995] 6 Med LR 139, QBD (refd)
Maynard v West Midlands Regional Healthcare Authority [1985] 1 All ER 635, HL (refd)
Mrs Kok Wee Kiat v Kuala Lumpur Stock Exchange Bhd & Ors [1978] 2 MLJ 123 (refd)
Multar v Lim Kim Chet & Anor [1982] 1 MLJ 184; [1982] CLJ 107, FC (refd)
Nadollek v Queen's Medical Centre [2002] EWCA Civ 1617, CA (refd)
Pacific Forest Industries Sdn Bhd & Anor v Lin Wen-Chih & Anor [2009] 6 MLJ 293, FC (distd)
Rogers v Whitaker (1992) 175 CLR 479, HC (refd)
Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] AC 871, HL (refd)
Siow Ching Yee (suing through his wife and litigation representative, Chau Wai Kin) v Columbia Asia Sdn Bhd [2024] 3 MLJ 66, FC (refd)
Vincent Manickam s/o David (suing by himself and as administrator of the estate of Catherine Jeya Sellamah, deceased) & Ors v Dr S Hari Rajah & Anor [2018] 2 MLJ 497; [2017] 8 CLJ 27, CA (refd)
Williams v Wilcox and another [1835-42] All ER Rep 25, QBD (refd)
Wiszniewski v Central Manchester Health Authority [1996] 7 Med LR 248 (refd)
Woodland v Essex County Council [2014] 1 All ER 482, SC (refd)
Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors [2017] 5 MLJ 438, FC (refd)

Legislation referred to

Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006 reg 11(4)
Private Healthcare Facilities and Services Act 1998

Appeal from: *Tan Sri Dato Mohd Hussin bin Abd Hamid v Gleneagles Hospital (Kuala Lumpur) Sdn Bhd & Anor* [2022] MLJU 2432 (High Court, Kuala Lumpur)

MS Dhillon (with Karthi Kanthabalan and Desmond Mun) (PS Ranjan & Co) for the appellant.
Amos Siew (with Tan Pui Yi) (Azim, Tunku Farik & Wong) for the first respondent.
Raja Eileen Soraya bt Raja Aman (with Latifa Haiqa bt Yusof) (Raja, Darryl & Loh) for the second respondent.

Supang Lian JCA (delivering majority judgment of the court):

INTRODUCTION

[1] This is the majority decision of the court. My learned brother, Kamaludin bin Md Said JCA had read the draft of this judgment and had agreed with the draft.

[2] The appellant, Tan Sri Mohd Hussin bin Abd Hamid, had brought a claim in medical negligence against the respondents for injuring his popliteal artery during an arthroscopy undertaken on his right knee. The arthroscopy was undertaken in the knee capsule. The popliteal artery was outside the capsule and at the back of the knee.

[3] To assist us in visualising the injury site, we reproduce a diagram lifted from the 'Ringkasan Eksekutif Perayu' (encl 45) which illustrates the position of the popliteal artery in relation to the capsule of the knee joint.

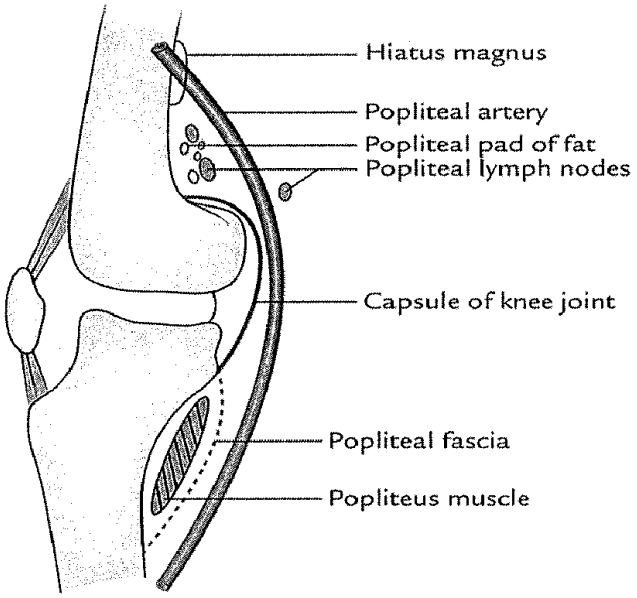


Diagram taken from earths/ab.comlanatomylpoplitea/artery

A **[4]** The appellant had undergone a surgical repair of the injured popliteal artery and had suffered and continues to suffer residual disabilities in his right leg.

B **[5]** The allegation of negligence by the appellant against the second respondent is in respect of the failure of the latter to warn him of the risk of injury to his popliteal artery and for negligently causing the injury.

C **[6]** As against the first respondent, the appellant's claim is in regard to its non-delegable duty of care and its vicarious liability for the negligence of the second respondent.

D **[7]** On 27 May 2022, the High Court, after a full trial, had dismissed the appellant's claim against the first and second respondents. Having dismissed the claim on liability, the learned trial judge did not proceed to assess damages.

[8] The appellant, unsurprisingly, is dissatisfied with the decision of the High Court and has brought this appeal before us against the whole of the decision.

E

BACKGROUND FACTS

F **[9]** The first respondent, Gleneagles Hospital (Kuala Lumpur) Sdn Bhd (first defendant at the High Court), is the owner of, and manages a private hospital known as Gleneagles Hospital Kuala Lumpur ('hospital').

G **[10]** The second respondent, Dr Charanjeet Singh (second defendant at the High Court) is a Consultant Orthopaedic & Trauma Surgeon who, at the material time, had a private medical practice at the hospital.

H **[11]** The appellant first presented himself at the second respondent's clinic at the hospital on 4 March 2013, when he consulted the second respondent with complaints of pain in his right knee over the preceding three weeks, especially after sitting cross-legged for a prolonged period of time in the mosque.

[12] The appellant also complained of difficulty in walking after sitting for a prolonged period of time.

I **[13]** During the consultation on 4 March 2013, the second respondent had noted the following:

(a) appellant had no history of any trauma or injury;

(b) appellant had a history of hypertension, diabetes mellitus and high

cholesterol and was on medication for the same; and

(c) appellant had a history of having undergone placement of a cardiac stent four to five years previously and was on medication (ie 'Plavix').

[14] After eliciting the appellant's history, the second respondent proceeded to carry out a clinical examination of him, and noted the following:

(a) there was no swelling on his knee;

(b) the right knee was in varus alignment;

(c) there was mild effusion in the knee joint;

(d) the medial joint line was tender on palpitation; and

(e) the lateral joint line and collateral ligaments were normal.

[15] The second respondent ordered for an x-ray to be performed on both appellant's knees and for an MRI to be performed on his right knee. He also advised that appellant be reviewed again after those investigations were completed.

[16] During a follow up on 6 March 2013, the appellant was reviewed by the second respondent. The latter informed him of the following:

(a) the x-rays of both knees revealed osteoarthritis with loose bodies in the joint; and

(b) the MRI of the right knee showed significant 'patella and medial femoral condyle cartilage loss and degeneration, joint effusion with loose bodies, tear of posterior horn of medial meniscus, contusion of the medial collateral ligament and posterior oblique ligament'.

[17] The second respondent advised the appellant to first attempt conservative treatment (lubricant injection). He had also advised appellant that if the pain persisted, he should consider the option of having a 'total knee replacement' or, 'right knee arthroscopy' to clean up the joint and remove the loose bodies that were causing the discomfort.

[18] The appellant opted to have a lubricant injection and the same was accordingly administered.

[19] As there was no improvement after the injection, the appellant consulted the second respondent again on 11 March 2013 with the same complaint. The latter carried out a clinical examination and noted that the appellant's right knee medial joint line was tender. The lateral joint line and cruciate ligaments were however normal. Based on his clinical findings, the

second respondent advised appellant to undergo a total knee replacement. The appellant, however, was reluctant to do so. The second respondent then advised him to rest and perform some knee exercises.

[20] The appellant returned to consult the second respondent on 12 December 2013 (approximately nine months later). During this consultation, he complained of persistent right knee pain at the medial aspect with no swelling. The second respondent carried out a clinical examination on him and noted there was some tenderness at the medial joint line coupled with patella femoral crepitus. The second respondent advised him with regard to a right knee 'arthroscopy, meniscus and cartilage work' ('the surgery').

[21] The second respondent explained to the appellant the following:

(a) that the purpose of the surgery was to remove loose bodies in the knee joint and to clean up the meniscus;

(b) that it would not be possible to repair the cartilage damage; and

(c) that the surgery may reduce some of the pain he was suffering from but would not resolve all the pain and that he would still continue to suffer pain from the cartilage damage.

[22] The second respondent advised the appellant of the nature of the surgery as well as the material risks associated with the surgery (bleeding, infection and blood clot).

[23] He, as well, advised appellant to stop taking blood thinners (Plavix) beginning five days prior to the surgery and advised him to get himself admitted into the hospital one day prior to the surgery for a consultation with Dr Faridah (Consultant Physician and Endocrinologist) due to his preexisting medical conditions ('diabetes' and 'hypertension').

[24] The appellant, having understood the explanation and advice given by the second respondent, agreed to undergo the surgery which was scheduled on 27 December 2013.

[25] On 27 December 2013, appellant underwent the surgery, a procedure known, as an arthroscopic debridement on the appellant's right knee which involved the exploration of the knee to remove all or part of a torn meniscus, to remove small loose fragments of cartilage and to address the damaged cartilage in the knee in order to lessen friction ('the first surgery').

[26] During the first surgery, the appellant was given anaesthetic and was

administered and monitored by Dato' Dr K Mohandas, a Consultant Anaesthetist at the first respondent. A

[27] On 30 December 2013, before the appellant was scheduled to be discharged, he noticed a blue-black mark on the right knee and experienced excruciating pain during the physiotherapy in triage conducted by Mr Danaraj Gunaratnam. An ultrasound doppler scan was carried out immediately on him by the Radiologist, Dr Moorthy Sinnasamy, and the same revealed a right popliteal artery pseudoaneurysm and right popliteal vein thrombosis. B

[28] The second respondent then referred appellant to Dr Lim Beng Kiat (Consultant Vascular Surgeon), Dr Moorthy Sinnasamy (Consultant Interventional Radiologist) and Dr Mohandas (Consultant Anaesthetist), for co-management. C

[29] In view of appellant's condition at the material time, Dr Lim Beng Kiat planned an exploratory surgery to repair the popliteal artery for him ('the second surgery'). D

[30] On 8 January 2014, Dr Lim Beng Kiat was assisted by second respondent to perform the second surgery. The popliteal pseudoaneurysm was resolved following the second surgery. An ultrasound doppler which was carried out on the respondent on 12 January 2014 revealed no deep vein thrombosis. E

[31] The appellant was discharged from the hospital on 14 January 2014. He was advised to attend follow-up consultation with Dr Lim Beng Kiat and the second respondent at their respective clinics. F

[32] Despite going through the second surgery, there was no improvement to the appellant's right knee. Further, the pain became considerably worse and as a consequence, his movements and activities were now restricted. G

[33] The appellant pleaded that due to the negligence of the respondents, he was required to extend his stay at the hospital for a continuous period of nineteen days which is in stark contrast to the mere two to three days that the second respondent had assured the appellant earlier. H

[34] It was in light of the above, that the appellant had brought the claim in medical negligence against the respondents in the High Court. I

FINDINGS OF THE HIGH COURT

Liability of the second respondent

[35] The learned trial judge found that the appellant failed to prove his case against the second respondent. The material findings of the trial judge in this regard are:

(a) the appellant was warned of the usual risk of bleeding within the capsule during an arthroscopy as he in his evidence said that he was aware of the same risk of bleeding as if he had opted for the total knee surgery;

(b) the appellant understood that bleeding would occur if a blood vessel was injured, and arteries were in fact blood vessels;

(c) the risk of popliteal artery injury was encompassed by the warning of risk of bleeding and other surgical complications, as advised to the appellant by the second respondent and documented in the consent form of the first surgery. Any person would have necessarily understood that bleeding would occur following an injury to the blood vessels or arteries;

(d) even if the second respondent had advised the appellant of the specific risk of popliteal artery injury, the latter would still have undertaken the first surgery because he was reluctant to undergo total knee replacement at the material time. He had no other option to alleviate his knee pain, other than the first surgery;

(e) as opined by all the expert witnesses, the popliteal artery injury was a *rare complication*. Moreover, Dr KS Sivanathan ('SD3'), had clearly explained why the popliteal artery injury was a rare complication;

(f) given all the above, the second respondent had sufficiently warned the appellant of the risk of injury to the popliteal artery. Therefore, there was no failure on the part of the second respondent to discharge his duty to properly advice, inform and warn the appellant on the risk of the first surgery;

(g) there were conflicting opinions advanced by the experts on how the popliteal artery may have occurred;

(h) the second respondent's expert witnesses, SD3 (Dato' Dr KS Sivananthan) and SD4 (Dr Vijeyasingam Rajasingam) were of the view that the likely cause of the injury was that a branch of a blood vessel which had been inadvertently sucked during the surgery had pulled the popliteal artery and caused an avulsion injury;

(i) whereas, Dr Kuldip Singh Dhillon ('SP2'), the expert witness for the appellant, maintained that the injury occurred when the instrument, ie, a scope and a shaver, used by the second respondent penetrated to the back of the knee when excessive force was used;

(j) there was no definite conclusion whether it was the scope or the shaver that could cause the avulsion injury, as theorised by the second respondent's experts. Notwithstanding this, all experts recognised the

possibility of a shaver causing an avulsion injury. The learned HCJ was inclined to accept the expert opinions of SD3 and SD4 that the injury was caused as a result of pulling or tugging of part of the tissues or vessels by the shaver used during the first surgery;

(k) the possibility of an avulsion injury was shared by all experts in this case, which dispels the misconception that the injury could only occur as a result of carelessness;

(l) the avulsion injury theory as advanced and explained by the second respondent's experts was acceptable with logical analysis. SD3 had explained in detail and in a very comprehensive manner that it was practically impossible to exert excessive force using the blunt shaver;

(m) the excessive force theory advanced by the appellant which assumes that carelessness alone was the only explanation that has caused the injury was simply devoid of logical deduction and could not be accepted;

(n) given the use of a blunt instrument, the excessive force theory, which involved penetration through the knee capsule to reach the popliteal artery which was located behind it, was simply not possible. Moreover, there were no signs of severe damage and bleeding during the first surgery which would have occurred if there was penetration through the knee capsule;

(o) SP2 did not describe or explain how the second respondent was careless in conducting the first surgery;

(p) SP2 did not explain what precautions and measures the second respondent as a reasonable competent practitioner in his field should have taken, but allegedly failed to. In any case, the experts were of the opinion that an avulsion injury may occur despite precautions and SP2 had agreed to this proposition;

(q) having regard to the testimonies of the experts, the opinion proffered by the second respondent's experts was to be preferred and the theory advanced by SP2 to be rejected as failing to withstand logical analysis; and

(r) given the above, the second respondent had taken reasonable precaution and had acted in accordance with practice and medical standards in performing the first surgery. He had also taken immediate steps in treating and managing the appellant's popliteal artery injury arising from the uneventful first surgery by referring the appellant to Dr Lim Ben Kiat for further treatment. There was no delay in the second respondent's treatment and management of the appellant's injury.

[36] Ultimately, the LHCJ found that the second respondent was not negligent in his performance of the first surgery.

Liability of the first respondent

[37] In view that the appellant has failed to prove negligence on the part of the second respondent, the trial judge found that the claim against the first respondent also failed.

ISSUES RAISED BY THE APPELLANT/PLAINTIFF IN THIS APPEAL

[38] The appellant has raised several issues in this appeal.

[39] Firstly, whilst the appellant has pleaded that the popliteal artery was pierced during the arthroscopy, the second respondent has not pleaded any alternative version of the causation. The avulsion injury theory put forward by the second respondent was raised in the course of evidence at the trial and was never pleaded in the statement of defence.

[40] Secondly, the respondents had a duty to provide advice and information regarding the risks involved during the arthroscopy. The appellant was told that the arthroscopy involved undertaking the operation within the capsule of the right knee. He was told that there would be bleeding within the knee capsule. However, the appellant was not advised of the risk of an injury outside the knee capsule including the popliteal artery.

[41] It was not established in the evidence that the second respondent had indeed explained the risk of popliteal artery injury to the appellant at any material time. In fact, the second respondent did not testify that he had warned the appellant of any such risk to the popliteal artery. The consent form makes no mention of any risk of injury to the popliteal artery.

[42] Counsel for the second respondent had suggested to the appellant that since he had been warned of the general risks of bleeding within the knee capsule, he should accept that such bleeding would include bleeding caused by an injury to the popliteal artery. The appellant rejected that suggestion and so did Dr KS Dhillon.

[43] The second respondent's expert indeed testified that the appellant should have been warned of the risk of an avulsion injury to his popliteal artery. However, such warning was not mentioned in the respondents' witness statements, pleadings, medical records, consent form and medical reports and medical records.

[44] It is not disputed that the appellant was warned of the general risk of bleeding within the capsule during the arthroscopy but he was not warned of the risk of an injury to any arteries outside the capsule.

[45] The *Bolam* test does not apply to the standard of care in providing advice and information. The test to apply is a patient standard test, namely, what a reasonable patient would expect to be told about the risks of an injury to his popliteal artery when undergoing an arthroscopy

[46] The contents of documentary evidence must be given more weight compared to the oral evidence or to the 'postulation' of the second respondent.

[47] The respondents were under a duty but had failed to give a plausible explanation.

[48] The Court of Appeal is therefore entitled to set aside the findings of fact which are not supported by the evidence and the pleadings and make its own findings of fact.

[49] Thirdly, the learned trial judge has failed to consider sufficiently or at all the evidence and the law regarding the first respondent's non-delegable duty of care and its vicarious liability for the negligence of the second respondent.

[50] The appellant had pleaded breach of Private Healthcare Facilities and Services Act 1998 Act and its regulations in sub-paras 19.20 and 19.30 of the statement of claim.

[51] Fourth, the learned trial judge has erred in not giving a decision on quantum, notwithstanding that the claim on liability has been dismissed.

[52] That being the case, this court has two options: either to order damages to be assessed by a different High Court judge or to assess the damages at the hearing of the appeal.

ANALYSIS AND DETERMINATION

Unpleaded avulsion injury theory

[53] In more detail, the appellant argued that he has pleaded in para 11 of the statement of claim that the popliteal artery was pierced during the arthroscopy, but the respondents did not plead any alternative version of the causation. The first respondent has merely pleaded that an exploration of the popliteal artery and evacuation of a haematomawas undertaken but did not plead how the popliteal artery was injured (para 9.10 of the first defendant's defence). The second respondent, on the other hand, pleaded 'repair of the popliteal artery' but did not plead how the popliteal artery was injured (see para 10.10 of the second respondent's defence).

[54] At the trial, the appellant's expert had testified that the use of excessive force during the arthroscopy could have caused the scope to pierce through the knee capsule and injured the popliteal artery that was situated outside the knee capsule. This is referred to as the excessive force theory. The second respondent and his experts disagreed with that theory.

[55] Instead, counsel for the second respondent came up with an unpleaded theory that the scope 'had pulled on a small branch of the artery and caused a tear of the popliteal artery'. The appellant's expert, as well as the second respondent and his expert had disagreed with that theory.

[56] After the close of the appellant's case, the second respondent had introduced another new theory that was not pleaded and it is that the shaver had allegedly caused a 'tugging' injury to the popliteal artery. Appellant submitted that this second theory was actually an afterthought as this shaver theory was not put to the appellant's expert Dr KS Dhillon (SP2).

[57] The theory that either the scope or the shaver had caused a tugging injury to the popliteal artery is termed as the avulsion injury theory. It is the case for the appellant that the respondent's failure at trial to put to the appellant and his expert this non-pleaded theory is in breach of the rule in *Browne v Dunn* (1893) 6 R 67 at p71. Whereas, the effect of a judge making a decision on an issue not based on the pleadings, is a breach of *audi alterem partem,* a basic principle of natural justice (see *Pacific Forest Industries Sdn Bhd & Anor v Lin Wen-Chih & Anor* [2009] 6 MLJ 293).

[58] In reply, the second respondent contended that the excessive force theory relied on by the appellant as to how the popliteal artery injury occurred was also not pleaded. The reference to the word 'pierced' in para 11 of the amended statement of claim does not explain any theory of how the injury occurred. The excessive force theory in turn, was the evidence of the appellant's expert to support the appellant's case that the artery was indeed allegedly 'pierced'.

[59] We think it befitting, in this respect, to fall back on the fundamental rule of pleading that only material facts be pleaded and not evidence. The rationale for this rule of pleading is well put in *Dato' Gopal Sri Ram v Dato' C Vijaya Kumar & Ors* [2006] 6 MLJ 328 where the High Court said:

> [33] I can think of at least two reasons why the fundamental rule of pleading requires only concise facts be pleaded and not evidence.
>
> [34] First, in an action begun by writ in the adversarial system of justice a pleading as Lord Hoffmann said in *Barclays Bank v Boulter* [1999] 1 WLR 1919 at p 1923 'is meant to define the issues and give the other party fair notice of the case he has to meet'. The judge plays a purely non partisan role of a referee whose mind must be

kept pure and free from any prejudice and prejudgment until he sits at the trial and hears evidence. By pleading evidence rather than a concise statement of fact, there is a likelihood of compromising the neutrality of the judge consciously or subconsciously before he gets to hear the evidence.

[35] Second, a pleading is a privileged public document to which the public has access. The facts stated therein are purely allegations and counter allegations the truth of which may only be ascertained after evidence is presented and assessed by the judge. A statement by a party purporting to state therein evidence rather than concise fact may well be erroneously assumed to be true by others.

[60] With the above in mind, we quite agree with counsel for the second respondent that none of the parties have offended the rules of pleading on this issue.

[61] To our minds, the material fact is the injury sustained by the appellant. The theories of excessive force as advanced by the appellant or avulsion injury as proffered by the second respondent on how the injury could have occurred, are views that was required to be led through expert evidence and not material facts which must be pleaded.

[62] In this regard, it is to be observed that both parties have pleaded the nature of injury suffered by the appellant but not as to how the injury could have occurred.

[63] For instance, at para 11 of the amended statement of claim, the appellant pleaded that 'the Appellant's popliteal artery was pierced during the first surgery'. At para 14, the appellant went on to state that the ultrasound doppler examinations revealed that there were in fact right popliteal artery pseudoaneurysm and right popliteal vein thrombosis. Then again at para 26, the appellant has set out the particulars of injury.

[64] Conversely, the second respondent also pleaded material facts regarding the popliteal artery injury. At para 10.6 of the amended defence, it is pleaded that 'An Ultrasound Doppler was carried out and revealed a right popliteal artery pseudoaneurysm and right popliteal vein thrombosis'. Moreover, para 11 of the amended statement of claim was denied. The second respondent is allowed to raise in evidence why the averment cannot stand (see *Williams v Wilcox and another* [1835–42] All ER Rep 25); *Mrs Kok Wee Kiat v Kuala Lumpur Stock Exchange Bhd & Ors* [1978] 2 MLJ 123).

[65] In any event, the excessive force theory relied on by the appellant as to how the popliteal artery injury occurred was also not pleaded. The use of the word 'pierced' in para 11 of the amended statement of claim does not explain any theory of how the injury occurred. That word as pleaded, in my view, only

described the nature of the injury and not how the appellant thought the injury had occurred. Clearly, the excessive force theory was the expert evidence by the appellant's expert to support the appellant's case that the artery was indeed allegedly 'pierced'.

[66] Additionally, it is apparent that the avulsion injury theory was raised and addressed by the second respondent's counsel during trial in response to the excessive force theory which was first raised by the appellant's expert during the trial. It was never mentioned in the expert report that was filed by the appellant.

[67] It is apparent to us that the complaints and stance taken by the appellant on this issue of the pleadings is like the pot calling the kettle black, as the old saying goes. All to no avail. As stated earlier, none of the parties has fallen short of the rules of pleading on this issue as both parties have pleaded the material fact of the injury that was sustained during the first surgery.

[68] Given that the experts' views on how the injury could have occurred are matters of expert evidence and not material facts which must be pleaded, the case authorities *Browne v Dunn* and *Pacific Forest Industries* cited in support of this by the learned counsel for the appellant have no application.

THE LAW ON MEDICAL NEGLIGENCE

[69] The test to determine what is the standard of care demanded of a doctor is as enunciated in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, where McNair J stated as follows on the standard of proof in a medical negligence suit:

> The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art ... in the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time ... *I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art ... Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that would take a contrary view*. (Emphasis added.)

[70] The *Bolam* test approach practically meant that while the law imposed a duty of care, the standard of care owed by a doctor to a patient is left to the medical fraternity ie the 'practice accepted as proper by a responsible body of medical men skilled in that particular art'. In other words, the medical

practitioners had the final say whether there was negligence and not the courts. A

[71] The *Bolam* test withstood the test of time until almost thirty years later when an attempt was made to introduce a different test, specifically in respect of a medical practitioner's duty to advise as opposed to the duty to diagnose and treat. However, the House of Lords in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871, reaffirmed the test in *Bolam,* where Lord Scarman held: B

> The *Bolam* principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is a matter of medical judgment. C

[72] A doctor would not be negligent even where there were 'two schools of thought' provided he acted in accordance with one of them. The two schools of thought must also conform to the common or approved practice (*Maynard v West Midlands Regional Healthcare Authority* [1985] 1 All ER 635 (HL)). D

[73] It is evident that the *Bolam* test was applied to all areas of medical aspects such as diagnosis, treatment and advice. E

[74] There was further development on the legal status of the *Bolam* test in the United Kingdom. In 1997 the House of Lords decision in *Bolitho v City and Hackney Health Authority* [1997] 4 All ER 771 qualified the *Bolam* test by holding that if the body of medical opinion does not withstand logical analysis, the judge is entitled to hold the body of opinion as 'not reasonable or responsible' and thus reject that body of opinion. Lord Browne-Wilkinson stated: F G

> These decisions demonstrate that in cases of diagnosis and treatment there are cases where despite a body of professional opinion sanctioning the Respondent's conduct, the Respondent can be properly held liable for negligence. This is because in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied on is responsible, respectable or reasonable. In the vast majority of cases, the fact that distinguished experts in the field of particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view presuppose that the relative risks and benefits have been weighed by experts before forming their opinion. *But if in rare cases, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that body of opinion as not reasonable, respectable or responsible*. (Emphasis added.) H I

[75] *Bolitho* was significant because it has retained the courts' right to have

the final say on the issue of breach of duty of care in medical negligence cases concerning diagnosis and treatment. In effect, *Bolitho* retained the *Bolam* test for all purposes in respect of medical negligence, but made it subject to the condition that for the expert opinion to be acceptable to the courts, it must be capable of withstanding logical analysis, meaning to say, if the body of medical opinion does not withstand logical analysis, the court may hold that such opinion is not reasonable or responsible and may then depart from it.

[76] The *Bolitho* test is the extension of the *Bolam* test, which calls upon the court to analyse the logic and reasonableness of the conflicting medical opinion advanced by the experts before accepting the same wherein the court must assess whether such opinion is susceptible to logical analysis.

[77] The *Bolam* test as modified by *Bolitho* has been applied by the Malaysian courts for some time until the Federal Court decision in *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593 (FC), which followed the Australian High Court decision in *Rogers v Whitaker* (1992) 175 CLR 479. The High Court of Australia in *Rogers v Whitaker* took the view that the standard of care and factors to determine whether there was a breach of duty vary according to whether it involves diagnosis, treatment or provision of information or advice, and in that regard held that:

> The duty of a medical practitioner to exercise reasonable care and skill in the provision of professional advice and treatment is a single comprehensive duty. However, the factors according to which a court determines whether a medical practitioner is in breach of the requisite standard of care will vary according to whether it is a case involving diagnosis, treatment or the provision of information or advice; the different cases raise varying difficulties which require consideration of different factors.
>
> ...
>
> There is a fundamental difference between, on the one hand, diagnosis and treatment and, on the other hand, the provision of advice or information to a patient. In diagnosis and treatment, the patient's contribution is limited to the narration of symptoms and relevant history; the medical practitioner provides diagnosis and treatment according to his or her level of skill. However, except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo it. In legal terms, the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended. But the choice is, in reality, meaningless unless it is made on the basis of relevant information and advice. Because the choice to be made calls for a decision by the patient on information known to the medical practitioner but not to the patient, it would be illogical to hold that the amount of information to be provided by the medical practitioner can be determined from the perspective of the practitioner alone or, for that matter, of the medical profession.
>
> Whether a medical practitioner carries out a particular form of treatment in

accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often a decisive, role to play; whether the patient has been given all the relevant information to choose between undergoing and not undergoing the treatment is a question of a different order. Generally speaking, it is not a question the answer to which depends upon medical standards or practices. Except in those cases where there is a particular danger that the provision of all relevant information will harm an unusually nervous, disturbed or volatile patient, no special medical skill is involved in disclosing the information, including the risks attending the proposed treatment.

... *The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This duty is subject to the therapeutic privilege*. (Emphasis added.)

[78] In *Foo Fio Na* the Federal Court held as follows:

[36] ... We are of the opinion that the *Bolam* test has no relevance to the duty and standard of care of medical practitioner in providing advice to a patient on the inherent and material risks of the proposed treatment. The practitioner is under a duty bound by law to inform his patients who is capable of understanding and appreciating such information of the risks involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment.

[69] ... there is a need for members of the medical profession to stand up to the wrongdoings, if any, as is the case of professionals in other professions. In so doing, people involved in medical negligence cases would be able to obtain better professional advice and that the courts would be appraised with evidence that would assist them in their deliberations. On this basis, we are of the view that the *Rogers v Whitaker* test would be a more appropriate and a viable test of this millennium then the *Bolam* test ...

[79] The Federal Court decision of *Foo Fio Na* is limited to duty to advise on risk only. It does not deal with standard of care expected in respect of either diagnosis or treatment, thus the position is unclear in this respect.

[80] Following *Foo Fio Na*, our courts were divided in their views in respect of the standard of care in medical negligence cases. On one hand, there were cases that decided that the *Bolam* test no longer applied and that it was now for the courts to decide whether there has been a breach of the standard of care by a medical practitioner. On the other hand, there were decisions by the courts which emphasised that the test in *Foo Fio Na* and *Rogers v Whitaker* applies only to a medical practitioner's duty to advise or provide information to a patient and this does not apply to the standard of care that is expected from a medical

practitioner in respect of the duty to diagnose and to treat.

[81] The anomaly was finally put to rest by the Federal Court in *Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors* [2017] 5 MLJ 438 where it was held as follows:

> [97] ... The test propounded by the Australian case in *Rogers v Whitaker* and followed by this court in *Foo Fio Na* in regard to standard of care in medical negligence is restricted only to the duty to advise of risks associated with any proposed treatment and does not extend to diagnosis or treatment. With regard to the standard of care for diagnosis or treatment, the *Bolam* test still applies, subject to qualifications as decided by the House of Lords in *Bolitho.*

[82] The Federal Court in *Zulhasnimar* was of the view that in 'respect of the standard of care in medical negligence cases, *a distinction must be made between diagnosis and treatment on the one hand and the duty to advise of risks on the other*. This is because diagnosis and treatment are purely in the realm of medicine and in the field of medicine, there are genuine differences of professional opinion in respect of diagnosis and treatment'.

[83] With the Federal Court decision in *Zulhasnimar*, it is now clear that the *Rogers v Whitaker*'s test is restricted only to the duty to advise of risks associated with any proposed treatment and does not extend to diagnosis or treatment. With regard to the standard of care for diagnosis or treatment, the *Bolam* test still applies, subject to qualifications as decided by the House of Lords in *Bolitho*.

Whether the second respondent was negligent in his conduct of the first surgery in causing the injury to the popliteal artery

[84] The appellant has pleaded at para 11 of the statement of claim that the popliteal artery was pierced during the arthroscopy. On the other hand, the respondents did not plead any alternative version of the causation.

[85] The relevant pleadings of the respondents on this matter are as follows:

(a) at para 9.10 of the first respondent's defence, the first respondent pleaded that an exploration of the popliteal artery and evacuation of a haematoma was undertaken but did not plead how the popliteal artery was injured; and

(b) at para 10.10 of the second respondent's statement of defence, the second respondent pleaded 'repair of the popliteal artery' but did not plead how the popliteal artery was injured.

[86] From a perusal of the appeal records, the evidence at trial reveal that the

second respondent had, on 2 January 2014, noted in the medical records that 'the artery leak may need a surgery'. However, there is no record that the respondents had made a notation of how the popliteal artery was injured on 27 December 2013.

[87] The second respondent's consultant vascular surgeon Dr Lim Beng Kiat had in his medical report dated 8 January 2014 described the injury as a 'jagged tear of the popliteal artery of about 3–4mm', but there was no mention as to how the tear had occurred. Neither did the second respondent, in his medical report of 11 November 2014, mention how the injury had occurred.

THE SCOPE AND SHAVER THEORIES

[88] At trial, the appellant's expert, consultant orthopaedic surgeon Dr KS Dhillon (SP2 or Dr Dhillon), had testified that the use of excessive force during the arthroscopy could have caused the scope to pierce through the knee capsule and injured the popliteal artery that was situated outside the knee capsule. In reply to second respondent's counsel put question that the scope 'had pulled on a small branch of the artery and caused a tear of the popliteal artery', Dr Dhillon had answered 'unlikely'.

[89] It is noteworthy that the second respondent also disagreed with this theory advanced by his own counsel. The relevant part of his evidence is reproduced below:

> Q: Alright. And is it possible that, one second, Dr, let me just check something. Is it possible that the scope, don't shake your head yet, I haven't finished the question. *That the scope had pulled a small branch of the artery and caused the popliteal artery to tear*.
>
> A: Not probable at all.
>
> Q: In fact, you would say it is an implausible explanation. Correct, Dr?
>
> A: Agreed.
>
> Q: Do you agree?
>
> A: *Yes, scope cannot pull anything, there's no suction on the scope*.

[90] Likewise, Dr Dhillon disagreed with this theory. He testified as follows:

> Q: Sorry, let me repeat that. Is it possible that another explanation is that the scope, that biunt instrument had pulled on a small branch of the artery and caused a tear of the popliteal artery? Is that a possible explanation?
>
> A: *Unlikely*.
>
> Q: But possible?

A: Possible.

...

Q: Excessive force. Now, you were asked about the scope may have pulled on a small branch of an artery and caused a tear of the popliteal artery. You said *unlikely but possible*. Why do you say unlikely?

A: *Because the scope has no hook on it to pull on any structure*. But if you go pass the structure and you suddenly bend the scope, then you then you may cause damage to the vessel.

[91] The second respondent's expert, Dr KS Sivananthan (SD3 or Dr Sivananthan), also agreed that the scope could not have caused the popliteal artery tear. According to him, it was the shaver that could have avulsed the artery from the popliteal causing the avulsion injury. His evidence is as follows:

Q: During the Appellant's case, my learned friend who appears for Dr Charanjeet had suggested to the Appellant's Expert that the scope had tugged a part of the artery in the compartment and forced the popliteal artery tear. Can the scope do that?

A: As I mentioned, the scope, because it's a sucking instrument and shaving instrument, a branch of the artery could get within the joint and could have avulsed the artery from the popliteal ... it could cause avulsion injury.

Q: You didn't understand my question, then. Can the scope, the camera ... that is my question. Doctor ...

A: Oh, not the camera, definitely not the camera, it is a shaver. I'm sorry I didn't get the question right.

Q: To suggest that the camera had caused such an injury would be incredible?

A: *Camera can never do that*.

...

Q: It's about what was put by my learned friend to the Appellant's Expert as to how the injury had occurred. So I'm going to read that part, Doctor, this is Dr Kuldip Singh Dhillon's cross-examination by my learned friend at page 12, 'Sorry, let me repeat, that is it possible that another explanation ...', Dr Kuldip had said, 'A direct injury', my learned friend is suggesting another explanation, '... that another explanation is that the scope, that blunt instrument, pulled on a small branch or the artery and caused a tear of the popliteal artery. Is that a possible explanation. Dr Kuldip said, 'Unlikely'

A: As you have already clarified before, *a scope cannot cause this injury, it is the shaver that caused this injury*.

Q: And in regard to the shaver, Doctor, it will be a traction injury?

A: Yes, avulsion.

Q; Avulsion is because of traction?

A: Yes.

Q: So, there must be traction within the compartment forcing an avulsion to an artery which is outside the compartment?

A: Yes, yes.

[92] It will be noted that this theory, namely, that it was the shaver that had pulled a small artery in the knee capsule which had then gone on to tug the popliteal artery which was situated outside the knee capsule, was raised by the second respondent after the close of the appellant's case. This new theory is not pleaded and not mentioned in the second respondent's witness statement. During the trial, the second respondent had described the second new theory as his 'postulation'. The appellant submitted that this second theory was actually an afterthought. Moreover, this shaver theory was not put to the appellant's expert Dr KS Dhillon. The shaver theory or rather the shaver postulation as the second respondent puts it, was only introduced after the close of the appellant's case.

[93] Based on the records before us, it is apparent that the two new theories or postulation of either the scope or the shaver or both had tugged a small artery in the knee capsule and caused an avulsion injury to the popliteal artery was not put to the appellant; was not pleaded, was not mentioned in the witness statements; and was not mentioned in the medical records and the medical reports.

[94] Furthermore, it is evident from the testimony of second respondent's expert Dr KS Sivananthan, that the medical records do not show how this avulsion injury to the popliteal artery could have occurred. Reference is made to his testimony as follows:

Q: But you have not seen in any of the medical records or even in the Defence, Dr Charanjeet giving such a theory?

A: I have not seen Charanjeet's statement how this injury occurred.

Q: I'm talking about in the medical records?

A: Also there is no ...

Q: Because we're taking of contemporaneous medical records, there's no mention at all.

A: Because you see ... can I explain?

Q: You can answer the question, then you can explain.

A: You see, in the medical record, I have not seen any, even Charanjeet's medical record and in the hospital record how the artery was avulsed but it was only said that after two days that there was a pseudoaneurysm, that's all it was stated. But how the

A pseudoaneurysm occurred, *it was not mentioned in the medical report*.

Q: Certainly Doctor, if this is how it had occurred, an explanation should have been given to the patient regarding the mechanism as to how the injury had occurred?

A: Yes.

B

Based on the evidence before the trial court, the learned HCJ found that there was no definite conclusion whether it was the scope or the shaver that could result in an avulsion injury. This is a finding of fact which we, at the appellate level, would not be minded to disturb.

C

[95] The learned High Court judge heard the evidence on parties' respective theories in respect of the injury sustained by the appellant. Upon hearing both parties, she found that the excessive force theory advanced by the appellant was unable to withstand logical analysis and preferred the avulsion injury theory by the second respondent. This is a finding of fact by the trial judge.

D

[96] In our opinion, whether the injury was caused by the scope or shaver is immaterial. The question is whether by using such instrument ie the scope or the shaver or both, the second respondent had acted carelessly/negligently in causing the injury to the appellant. The appellant's theory is that the use of excessive force during the arthroscopy could have caused the scope to pierce through the knee capsule and injure the popliteal artery that was situated outside the knee capsule. According to SP2 (Dr Dhillon), the second respondent did not take enough precautions, used the scope and penetrated to the back of the knee and that is the only way to injure the popliteal artery. On the other hand, the respondents' theory was that either the scope or the shaver had pulled a branch of blood vessel in the knee capsule, which was inadvertently sucked during the surgery, and had pulled the popliteal artery and caused an avulsion injury.

E

F

G

[97] As opined by all expert witnesses, the popliteal artery injury was a rare complication.

H

[98] The trial judge was inclined to accept the expert opinions of SD3 (Dr Sivananthan) and SD4 (Dr Vijeyasingham) that the injury was caused as a result of pulling or tugging of part of the tissues or vessels by the shaver used during the first surgery. On the other hand, the learned HCJ was unable to accept SP2's reasoning on how the popliteal artery injury occurred since the instruments used for the first surgery were blunt instruments (scope) and it is doubtful for such a blunt instrument to penetrate the knee capsule and reach the back of the knee without signs of severe damage and bleeding during the first surgery.

I

[99] There was no description by SP2 as to the carelessness on the part of the second respondent in performing the first surgery. The trial judge was of the View that the assumption of carelessness alone as the only explanation that has resulted in the injury could not be accepted and devoid of logical deduction.

[100] The trial judge also found that SP2 did not clearly state what are the sufficient precautions to be undertaken by the second respondent that fell below the standards of a reasonable competent practitioner in his field in preventing the penetration of instruments through the back of the knee and eventually to avoid the injury. The experts also were of the opinion that an avulsion injury may occur despite precautions.

[101] The trial judge thus found that the appellant has failed to prove that the cause of the injury to the popliteal artery was due to the breach in the standard of care by the second respondent during the arthroscopy so as to avoid injury to the popliteal artery. The evidence of injury alone is insufficient to conclude that the second respondent has breached the standard of care during the first surgery.

[102] Having regard to the testimonies of the experts, the learned High Court judge preferred the opinion proffered by the second respondent's experts and rejected SP2's theory as failing to withstand logical analysis.

[103] We are in total agreement with the findings of the learned HCJ in this regard. We find that the second respondent was not negligent in his diagnosis and treatment in performing the arthroscopy. There were plausible explanation including by his expert as to how the injury to the popliteal artery could have occurred. We refer to the testimony of SD3, Dr KS Sivananthan as follows:

> Q: The Appellant's Expert has also testified, Dato', I'm moving on, that probes can tear the popliteal artery, that was the Appellant's Expert's evidence. Do you agree with that?
>
> A: *No, I disagree because I showed you the probe, this is a blunt probe, it is not sharp, so it is very difficult to go through the capsule and tear that. And even if it goes through the capsule, there are three structures here, there is an artery, vein, nerve, that means all these structures would have been damaged, not a single artery. So even if you put that, use all your force, all these three structures would have been damaged, not just damaging just the artery*. So, that is another explanation why I say it is not possible. *And even if you put a shaver also, if you poke right through that, it will damage all these structures. In this case, the damage was only to the artery, not to the vein*. The structure that is easily damaged in this scenario is the vein, not the artery because vein is a thin-walled structure, you see the blue thing that I showed you is a thin-walled structure whereas artery is a thick-walled structure. So, if it is due to either the probe or to the shaver, the vein is the one that's most likely to be damaged. (Emphasis added.)

[104] Premised on the forgoing, we find that the appellant's theory does not withstand logical analysis. If the appellant's theory is preferred, surely there must be some damage caused to other structure such as vein and nerve which would have caused excessive bleeding during the surgery, which did not occur here.

[105] Further, there was nothing on record to show that the second respondent had acted negligently in performing the first surgery which caused the popliteal artery injury. SD3 clearly said in his evidence that this problem (avulsion injury) could have happened to any surgeon and that there are no special steps to take to avoid bleeding from the small artery. He further testified that even when exercising care and skill, he may tug an artery through the shaver which can cause an avulsion injury and that it is impossible for the surgeon to be aware because there was no excessive bleeding during the surgery. His evidence is as follows:

> Q: So Dato', this avulsion injury that you mentioned, was that an injury that the surgeon in this case could have reasonably taken steps to avoid or prevent?
>
> A: As I told you, as a surgeon, when I see the arthroscope, I can't see the vessels, you see, it's all white because the blood vessels have been ... [unintelligible] ... because of the tourniquet, there is no blood in the blood vessels, so you can't differentiate the blood vessels from the pathological tissues, you see. If you can show me an arthroscopic picture later, I'll show you. it's very difficult to see this collapsed vessel in this pathological tissue. *So, this can happen to any surgeon, even with the best of precaution*.
>
> Q: So just to be clear, were there any reasonable steps that this surgeon could have taken to avoid the avulsion injury? Was there?
>
> A: If he has done the procedure as I have described, seeing the tissues that have been debrided with the arthroscope, I think this problem could have happened to any surgeon. There is no special steps to take to avoid bleeding from the small artery.
>
> Q: And he is also aware, *even when exercising care* and *skill*, he may tug an artery through the shaver which can cause an avulsion injury in a given case?
>
> A: Yes.
>
> Q: Now, during the course of the cross-examination, you explained that the surgeon in this case could not have been aware of the avulsion injury because there is no excessive bleeding. Wait, I will check my notes. Sorry Dato', I will just read out what you said earlier, This was what you said, The surgeon will only be aware if there's bleeding post-operatively. So, basically my question is, *would the surgeon have been aware during the course of the procedure that there was an avulsion injury*?
>
> A: *It is impossible for the surgeon to be aware*. (Emphasis added.)

[106] SD4 in his testimony said that the injury to the popliteal artery was an avulsion injury which had occurred when the device used to scrap the bony

ends makes a small pull and a tear in the vessel, that is plugged-up immediately by the blood platelets. After some time, that platelet plug may give way. He further testified that if the avulsion is much more serious there would be immediate bleeding, catastrophic bleeding into the knee joint.

[107] Based on the evidence adduced at trial, we find that the learned HCJ has not erred in holding that the injury had indeed occurred without any act of negligence. We agree with the learned HCJ that the assumption of carelessness alone as the only explanation that has resulted in the injury cannot be accepted and devoid of logical deduction. The learned trial judge is entitled to reject or depart from the opinion of the appellant's expert evidence if the opinion does not withstand logical analysis, as clearly stated in *Bolitho*.

[108] We therefore find that the second respondent had acted in accordance with a practice and medical standard while performing the first surgery. He also had taken immediate steps in treating and managing the appellant's popliteal injury arising from the first surgery by referring the appellant to Dr Lim Beng Kiat for further treatment. There was no delay in the second respondent's treatment and management of the appellants injury.

[109] Hence, we agree with the learned HCJ that the appellant has failed to prove that the cause of the injury to the popliteal artery was due to the breach in the standard of care by the second respondent during the arthroscopy.

[110] Accordingly, we answer the question of whether the evidence of the second respondent's expert could stand up to logical analysis in the positive. Hence, we hold that the respondents did not breach the standard of care expected in diagnosis and treatment.

[111] We also find that the learned trial judge had taken into consideration all relevant evidence before arriving at her decision that the second respondent was not negligent in performing the arthroscopy and has provided a plausible explanation including by his experts as to how the injury to the popliteal artery had occurred. We are loathed to intervene and do not see any reason to disturb the finding of the learned trial judge.

[112] Therefore, we do not see any merit in this issue raised by the learned counsel for the appellant and dismiss the same.

Was there a duty to inform of the specific risk of a popliteal artery injury?

[113] Regardless of how the popliteal artery was injured, the respondents had a duty to provide advice and information regarding the risks of the arthroscopy.

[114] The *Bolam* test, as stated earlier, does not apply to the duty to provide advice and information.

[115] The Federal Court decision of *Zulhasnimar* made it clear that the *Rogers v Whitaker* test is restricted only to the duty to advise of risks associated with any proposed treatment and does not extend to diagnosis or treatment. With regard to the standard of care for diagnosis or treatment, the *Bolam* test still applies, subject to qualifications as decided by the House of Lords in *Bolitho*.

[116] In *Zulhasnimar*, the Federal Court confirmed that the standard of care on the duty to advise of material risks is that decided in *Foo Fio Na* where the Federal Court adopted the test by the Australian High Court in *Rogers v Whitaker*. The risk is material if:

(a) in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or

(b) if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.

[117] In the present case, the second respondent owed a duty to advise the appellant on the risks associated with arthroscopy.

[118] In this regard the appellant submitted as follows:

(a) the appellant was told that the arthroscopy involved undertaking the operation within the capsule of the right knee. He was told that there would be bleeding within the knee capsule;

(b) the appellant was not advised of the risk of an injury outside the knee capsule including the popliteal artery;

(c) the second respondent did not testify that he had warned the appellant of any risk to the popliteal artery. The consent form makes no mention of any risk of injury to the popliteal artery;

(d) learned counsel for the second respondent had suggested to the appellant that since he had been warned of the general risks of bleeding within the knee capsule that he should accept that such bleeding will include bleeding caused by an injury to the popliteal artery. The appellant rejected the suggestion;

(e) the appellant's expert had also disagreed with such suggestion regarding the warning of risks;

(f) the second respondent's expert Dr Sivananthan had testified that the risk of an avulsion injury to the popliteal artery should be explained to the appellant;

(g) the risk of injury to the popliteal artery was therefore a foreseeable risk and the appellant should have been warned of such risk occurring;

(h) none of the experts had testified that there was no duty to warn of any risk of injury to the popliteal artery;

(i) the warning of the risk of injury to the popliteal artery was not mentioned in the respondents' witness statements, pleadings, medical records, consent form and medical reports;

(j) it is not disputed that the appellant was warned of the general risk of bleeding within the capsule during the arthroscopy but he was unfortunately not warned of the risk of an injury to any arteries outside the capsule; and

(k) in this case the risk of injury to the popliteal artery was a *material risk*, which was not advised to the appellant. Dr Sivananthan had testified that a surgeon should be aware of the risk of an avulsion injury caused by the tugging of an artery.

[119] On the duty to advise, the second respondent contended as follows:

(a) second respondent had sufficiently warned the appellant of the usual risk of bleeding within the knee capsule during the first surgery;

(b) the risk of popliteal artery injury was encompassed by the warning of the risk of bleeding and other surgical complications, which was advised by the second respondent to the appellant;

(c) given the rarity of the popliteal artery injury, the second respondent did not owe the appellant the duty to advise of the said risk specifically;

(d) even if the second respondent had advised the appellant of the specific risk of popliteal artery injury, it was apparent from the evidence that the appellant would still have agreed to undertake the first surgery;

(e) it was also agreed by SP2 that the risk of bleeding, regardless of the cause, was a risk which was highlighted to the appellant; and

(f) SD3 stated in his report that 'Injury to the vessels is a risk factor in an operation of the knee'. In the consent form, Dr Charanjeet had mentioned that bleeding is one of the risk factors. Bleeding can occur following injury to the vessels.

A FINDINGS AND ANALYSIS

[120] The consent form states as follows as regards the surgical complications that the appellant was advised of:

B Nature and purposes of the procedure/surgery*, the benefit and risks of the operation or procedure, the possibilities of complicationsl and the alternatives to this operation or procedure and their risks and benefits as stated below, have been explained to the patient/spouse/parent/guardian/next-of-kin of the patient*

* Bleeding

C * Infection

* Others

* Deep vein thrombosis

D * Persistence of OA pain which may not be able to reverse.

[121] The second respondent testified that he had, prior to the first surgery, warned the appellant of the risks of bleeding, infection, blood clot, meaning deep vein thrombosis.

E

[122] The second respondent did not give any evidence to say that he had warned the appellant of the risk of injury to the popliteal artery, it was also not put to the appellant during cross-examination that the second respondent had prior to the first surgery specifically warned him of the risk of injury to the F surrounding blood vessels, including the popliteal artery.

[123] Counsel for the second respondent had during her cross-examination of the appellant taken the position that the warning of the risk of 'bleeding' would necessarily include the risk of injury to the surrounding arteries, G including the popliteal artery.

[124] The appellant (SP1) had however disagreed, and explained that his understanding of the word 'bleeding' did not include the risk of injury to the H surrounding arteries. *The appellant had also testified that if he was warned of the risk of injury to a 'vessel' he would not have undergone the arthroscopy*:

RES: Now can you confirm, Tan Sri the information if you see on that last, the last section on page 418, the information contained in that last section, that was communicated to you? Tan Sri those were the risk of the surgery that was I communicated to you?

HUSSIN: Yes.

RES: Yes?

HUSSIN: Yes,

RES: And that risk, Tan Sri we can see included the risk of bleeding. Correct?

HUSSIN: Yes.

RES: Yes. Now your understanding of, Tan Sri would you confirm that bleeding mean that some vessel or some parts may be injured that may result in bleeding? That's how bleeding happens. Would you accept that?

HUSSIN: Can you please repeat that, please?

RES: Yes. That bleeding is would mean that some vessel or some parts may be injured that may result in bleeding?

HUSSIN: No.

RES: That was the risk that was —

HUSSIN: No. My understanding is bleeding is that, is when you have an operation, definitely will bleed, because there were cuts.

RES: Something will be cut?

HUSSIN: Yes. But cutting of vessel is not within my understanding of bleeding.

RES: But surely, when something is cut, if a vessel is cut similarly, it would be —

HUSSIN: Yes, but the vessel is just behind the knee.

RES: Yes.

HUSSIN: It's just highly impossible to be cut. So the bleeding, when you cut anything, when you cut your hand it bleeds. That is my understanding of bleeding, you know.

RES: Yes. When you cut your hand, it bleeds, because some blood vessel had been injured. That's why it bleeds, Tan Sri.

HUSSIN: True.

RES: Yes.

HUSSIN: Blood vessel and the artery vessel are two different things.

RES: And it would include, Tan Sri, I would suggest to you that the risk of bleeding would include the risk of a vessel or an artery being injured. Would you agree or disagree?

HUSSIN: My understanding that bleeding means parts of your body are cut, it bleeds. It doesn't include cutting the artery, the arteries. *Because you cut the arteries, then I would not even go through the whole entire operation, if I have known that*. But to be fair to the Court here, when I signed this, I didn't read any of this. I just signed. (Emphasis added.)

[125] The appellant said that the second respondent had given him two surgical options, that is, a total knee replacement or an arthroscopy. He said that following discussions with the second respondent he had decided to undergo the arthroscopy.

[126] The appellant said that he had been warned of the risk of bleeding at the operation site. However, he was not warned of the risk of injury to the surrounding arteries, including the popliteal artery.

[127] The appellant's expert Dr KS Dhillon (SP2) also said during cross-examination that the risk of bleeding during surgery is different from the risk of injury to an artery:

> RES: Now both I think in the consent form and in the entries that you saw just now the risk of bleeding was explained to the Appellant, based on the records that you have seen, right?
>
> KULDIP: Yes.
>
> RES: Now would you agree that bleeding in this context would include injury to any artery or veins that may result in bleeding.
>
> KULDIP: *No, I don't agree*. *Vessel injuries are separate from bleeding during surgery*.
>
> RES: Vessel injury would result in bleeding, correct?
>
> KULDIP: Sorry?
>
> RES: Vessel injury may result in bleeding?
>
> KULDIP: Can be what?
>
> RES: Vessel injury, just now you used the word vessel. Vessel injury may result in bleeding.
>
> KULDIP: Can't get the last word. Vessel injury?
>
> RES: May result, sorry it's the mic.
>
> KULDIP: In bleeding? Yes.
>
> RES: May result in bleeding.
>
> KULDIP: Yes, definitely.
>
> RES: And injury to an artery may also result in bleeding?
>
> KULDIP: Yes.
>
> RES: *So would you agree that explaining the risk of bleeding in the context of this procedure would include the risk of injury to any artery or vessel that may result In that consequence of bleeding*.
>
> KULDIP: *No*. (Emphasis added.)

[128] Dr Dhillon (SP2) had also testified as follows during re-examination:

> PSR: Now regarding bleeding. You were asked this morning, there are a number of questions including this point that puncture of the popliteal artery would lead to bleeding. Now, in the cases that you had undertaken where there was no injury to the popliteal artery was there bleeding?

KULDIP: Yes, there can be bleeding.

PSR: Yes. And what is the practice?

KULDIP: Practice?

PSR: About telling patient of bleeding

KULDIP: Yes. We, we tell them that whenever surgery is done, bleeding can occur.

PSR: *Now, Dr. In this case, anything to show that the patient was warned that there can be a surgical injury to the popliteal artery*?

KULDIP: *No*. (Emphasis added.)

[129] The respondent's expert Dr Sivananthan (SD3) gave the following evidence regarding bleeding during arthroscopy:

(a) that in any arthroscopy there will be some amount of bleeding;

(b) that some patients will bleed more and some patients will bleed less; and

(c) that the appellant, who was previously on blood-thinning drugs, had a higher risk-profile for bleeding than other patients who were not on such drugs.

[130] He also agreed during cross-examination that bleeding from a popliteal artery tear is not the usual type of bleeding one is concerned with when it comes to arthroscopy:

MSD: Although stopped about five days earlier, his risk profile for that bleeding in an operation would be higher than other patients?

SD3: Yes.

MSD: And this is the usual type of bleeding that will be seen in an arthroscope operation?

SD3: Yes.

MSD: The popliteal artery tear Is not the usual type of bleeding that the surgeon will be concerned about in an arthroscopy?

SD3: *Popliteal artery tear* in *an arthroscopy* is *extremely rare*.

MSD: *So, it is not the usuai type of bleeding that he is concerned with*?

SD3: *Yes*. (Emphasis added.)

[131] Dr Sivananthan (SD3) had also agreed during cross-examination that the surgeon should warn the patient of the risk of injury to the artery before the operation:

MSD: *But the surgeon, being aware of the anatomical structures and variations, will be aware of the possibility of an avulsion injury?*

SD3: *Yes.*

MSD: And he is also aware, even when exercising care and skill, he may tug an artery through the shaver which can cause an avulsion injury in a given case?

SD3: Yes.

MSD: *So, the surgeon, before undertaking the operation, should explain to the patient?*

SD3: *Yes.* (Emphasis added.)

[132] Dr Dhillon (SP2) had also given evidence that the appellant should have been warned of the risk of such injury occurring:

PSR: Alright. You wrote here, 'no justification for performing such a surgical procedure in this patient which carries the risk of perioperative morbidity and mortality'. This peri-operative morbidity that you saw here, what is it?

KULDIP: Vascular Injury

PSR: *Alright. Should the patient be warned of it?*

KULDIP: *Yes.*

PSR: Alright. At how it can arise —

KULDIP: Yes?

PSR: From the use of instruments?

KULDIP: Yes

PSR: *Now, Dr. In this case, anything to show that the patient was warned that there can be a surgical injury to the popliteal artery?*

KULDIP: *No.* (Emphasis added.)

[133] The expert evidence of both Dr Dhillon (SP2) and Dr Sivananthan (SD3) shows that the risk of bleeding at the operation site in the knee capsule is something *very different* from the risk of injury to an artery outside the capsule. SD3 also testified that it is not the usual type of bleeding that is concerned with the surgery, and that the popliteal artery tear in an arthroscopy is *extremely rare*.

[134] In the circumstances we do not agree with the learned trial judge that the second respondent's proposition that the warning of the risk of 'bleeding' would necessarily include the risk of injury to the surrounding arteries, including the popliteal artery.

[135] Based on the above evidence it is clear to us that the duty to warn of the risk of bleeding is different as compared to the duty to warn of risk of an avulsion injury to the popliteal artery. Hence, we are of the view that the

learned HCJ had erred in finding that the risk of a popliteal artery injury was *encompassed by the warning of risk of bleeding* and other surgical complications, as advised to the appellant and documented in the consent form of the first surgery.

[136] The duty to advise of the risk associated with the surgery is specific in nature. We take the view that the second respondent had failed to advise the appellant on the material risk of a popliteal artery injury which is in contrast to the duty to advise on the risk of bleeding during the surgery. Although acknowledged to be an extremely rare complication by SP2 and SD3, it does not mean that it is not a material risk. The risk must be informed to the patient if it is a material risk that the patient would likely attach a significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk would be likely to attach significance to it (*Foo Fio Na*; *Rogers v Whitaker*).

[137] The second respondent's expert Dato Sivananthan had testified that the risk of an avulsion injury to the popliteal artery should be explained to the appellant. The relevant part of his evidence is reproduced below:

> MSD: And he is also aware, even when exercising care and skill, he may tug an artery through the shaver which can cause an avulsion injury in a given case?
>
> SD3: Yes.
>
> MSD: *So, the surgeon, before undertaking the operation, should explain to the patient?*
>
> SD3: *Yes.* (Emphasis added.)

[138] Based on the evidence, the second respondent was also aware of the inherent and material risk in his treatment. As such, the injury suffered by the appellant was foreseeable to the second respondent, but he failed to inform the appellant of the material risk.

[139] In *Elizabeth Chin Yew Kim & Anor v Dato' Ong Gim Huat (sued as public officer of Hospital Lam Wah Ee) and other appeals* [2017] 1 MLJ 328; [2017] 2 CLJ 274, Harmindar Singh Dhaliwal CJA (now FCJ), in delivering the judgment of this court, held as follows:

> [34] The principle of causation is concerned with the relationship between the tortious act and the injury sustained. There must be a causal connection between the breach of duty and the injury suffered. Now proof of causation can often be onerous for the injured patient as he or she is in most cases in a disadvantaged position when compared to the treating medical practitioner.
>
> [35] Nevertheless, the law places a burden on the appellant to prove on a balance of probabilities, as in the instant case, that it was the first respondent's breach of duty which caused the injuries to the infant. Put another way, there must be proof that if

there was no breach by the first respondent in his failure to apply the McRobert's manoeuvre and supra-pubic pressure, the infant would not have suffered the injuries that were sustained.

[36] In this regard, the courts often look to the test of causation commonly known as the 'but for' test. *It simply means that 'but for' the respondent's negligent act, the injury would not have occurred*. It is in essence, a factual inquiry and in medical negligence cases, it is often resolved through expert evidence. (Emphasis added.)

[140] In the present case, it is clear to us that, but for the second respondent's negligent act in his duty to advise on the risk, the appellant would not have opted for the surgery and suffered the popliteal artery injury.

[141] The consent form, signed by the appellant prior to the operation only contained general precautions that the operation involved risks ie:

* Bleeding
* Infection
* Others
* Deep vein thrombosis
* Persistence of OA pain which may not be able to reverse

[142] The second respondent had not warned the appellant of the risk of popliteal artery injury at any material time. The warning of the risk of injury to the popliteal artery was not mentioned in the respondents' witness statements, pleadings, medical records, consent form and medical reports. The second respondent did not testify that he had warned the appellant of any risk to the popliteal artery. In the circumstances we are unable to accept the second respondent's proposition that the risk of popliteal artery injury was encompassed by the warning of the risk of bleeding and other surgical complications, which was advised by the second respondent to the appellant.

[143] We are also unable to agree with the second respondent's submission that given the rarity of the popliteal artery injury, the second respondent did not owe the appellant the duty to advise of the said risk specifically. Neither do we agree that even if the second respondent had advised the appellant of the specific risk of popliteal artery injury, the appellant would still have agreed to undertake the first surgery. The appellant had clearly testified that if he was warned of the risk of injury to a 'vessel' he would not have undergone the arthroscopy.

[144] Given that previously, the appellant was not keen to have total knee replacement, it was apparent that the appellant would attach significance to

warnings of the risks associated with the first surgery ie the risk of an injury to the popliteal artery.

[145] In this case the second respondent's expert, Dr Sivananthan had testified that a surgeon should be aware of the risk of an avulsion injury caused by the tugging of an artery. He also testified of the need to warn of the risk of an avulsion injury to the popliteal artery. Clearly, the risk of injury to the popliteal artery was a material risk, but the appellant was not advised of it.

[146] The second respondent referred to *Dr Ismail Abdullah v Poh Hui Lin (administrator for the estate of Tan Amoi @ Ong Ah Mauy, deceased)* [2009] 2 MLJ 599 where the High Court held that:

> A close scrutiny of the evidence as contained in the record of appeal will reveal that it had not been established that acute pancreatitis and ARDS were 'material risks of the operation'. As stated at the beginning of this judgment, the plaintiff did not tender at all any expert evidence or factual medical evidence. Not one of the first defendant medical and expert witnesses said that acute pancreatitis and ARDS were material risks or commonly known risks of the operation. On the contrary, there's in fact medical evidence to suggest that liver failure, pancreatitis and ARDS could arise as a result of the deceased's pre-existing condition, namely the obstruction of the common bile duct by gall stones. The risks of ARDS and pancreatitis accruing as a result of the operation were very rare and minimal. *In my view there was no duty to inform the deceased of the very rare risk of such a thing happening. The deceased must only be informed by the first defendant of the material risks of the proposed operation*. (Emphasis added.)

[147] The second respondent also relied on *Christou v King Edward Memorial and Princess Margaret Hospitals Board of Management* [2007] WADC 44, where the Australian Court held that the doctor was not under a duty to warn the patient of the risk of a *rare complication.* The court held as follows:

> ... Nevertheless, I am satisfied on the balance of probabilities that each would have, in accordance with their usual practice, warned the plaintiff of the risks involved with the proposed surgery. In the case of Dr Cohen I am satisfied that he warned the plaintiff as to the risk of damage to nearby hollow structures or organs such as the bladder or the bowel. Those warnings were of material risks being risks which a reasonable person in the plaintiff's position would be likely to attach significance to. *I see no need for the plaintiff to have been warned, in the* circumstances *of her case, as to the small risk of perforation of the jejunum or small bowel. She would have been unlikely to differentiate, in any event, between the small and the large bowel*. In the circumstances of the plaintiffs case there is no basis for concluding that Dr Cohen, or Dr Kumar for that matter, should have been aware that the plaintiff, if warned of the risk of perforation of the jejunum would have been likely to attach significance to it.

[148] In both cases above, the court opined that there was no duty to inform

A the deceased of the very rare risk or the small risk. However, in our present case, we must not lose sight of the evidence led by the experts where the second respondent's expert Dato' Dr Siva (SD3) clearly admitted *on the need to warn of the risk of an injury to the popliteal artery*. Furthermore, none of the experts had testified that there was no duty to warn of any risk of injury to the popliteal B artery. In the circumstances, we are of the view that the risk of injury to the popliteal artery was therefore a foreseeable risk and the appellant should have been warned of such risk occurring.

C **[149]** We could not agree with the proposition put forward by the second respondent's counsel that the second respondent did not owe the appellant a duty to advise him of such a risk given the rarity of the risk, which requires no specific disclosure. On the contrary, we are of the view that in this case the risk of injury to the popliteal artery was a *material risk*, which was *not advised* to the appellant. It bears emphasis that the second respondent's own expert witness D had testified that a surgeon should be aware of the risk of an avulsion injury caused by the tugging of an artery.

[150] The test is whether the risk is a *material risk* inherent in the proposed treatment. A risk is material if, in the circumstances of the particular case, *a reasonable person in the patient's position*, *if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it*. This duty is subject to the therapeutic privilege (*Rogers* E *v Whitaker* (1992) 175 CLR).

F **[151]** To our minds, the second respondent owed a duty to inform the appellant of the risk be it a rare or small risk, so long as the risk is a material risk which the appellant would likely attach a significance to it or if the medical practitioner is or should reasonably be aware that the appellant, if warned of the G risk, would be likely to attach significance to it.

[152] In this context, the respondent's expert testimony (SD3) indicates that the appellant should have been made aware of the risk. Given this evidence H presented to the court, we are not persuaded to hold otherwise, as such a finding would clearly contradict the evidence before this court.

[153] We refer to the Federal Court case of *Dr Hari Krishnan & Anor v Megat Noor Ishak bin Megat Ibrahim & Anor and another appeal* [2018] 3 I MLJ 281 where it was held as follows:

> [74] We agree with the Court of Appeal in finding that *neither Dr Hari nor Dr Namazie warned the plaintiff of the risks of bucking and blindness at any material time. In the circumstances, a reasonable person in the patient's position would be likely to attach significance to it*. We further note that in relation to this particular patient,

given that the plaintiff has previously requested for scans to be conducted and enquired on the need for the operation, it is apparent that the plaintiff would attach significance to warnings of such risks. As such, we consider such risks to be material risks in the second operation. Following *Zulhasnimar,* applying the test in *Foo Fio Na* and *Rogers* in relation to the duty to advise of risks associated with any proposed treatment, we find no difficulty in concluding that the duty has been breached by Dr Hari and Dr Namazie. (Emphasis added.)

[154] Also, we are of the view that the second respondent's failure to inform the appellant of the risk associated with the surgery was clearly not in accordance with the practice accepted by a responsible body of medical practitioners. We say this because, the appellant's expert as well as the respondent's expert both have testified that the appellant ought to have been informed of the risk of an injury to the popliteal artery, to which the second respondent has failed to do so.

[155] For the reasons stated above, we find that the risk of an injury to the popliteal artery is considered to be a material risk and ought to have been explained to the appellant, but was not. Thus, we find that the second respondent had breached the duty to advise. He was therefore negligent and had deprived the appellant of the chance to make an informed decision as to whether to proceed with the surgery or otherwise. In our judgment, from the available evidence, the appellant has proven, on balance of probabilities, that the second respondent is liable in this medical negligence suit for his failure to advise the appellant on the material risk involved before the surgery was performed.

VICARIOUS LIABILITY

[156] In the present case, the first respondent took the position that the second respondent was carrying out his practice in the hospital at all material times, not as an employee, servant or agent of the hospital, but as an independent contractor. Hence, the issue of vicarious liability does not arise and the first respondent ought not to be held liable to appellant for the negligence of the second respondent, if any.

[157] The first respondent submitted as follows:

(a) second respondent has expressly admitted that he was carrying out his practice in the hospital at all material times as an independent contractor;

(b) appellant had executed a document called 'Terms and Conditions of Service' which confirms acceptance of the hospital's conditions of service, acknowledging/admitting that all medical consultants practicing in the hospital, including second respondent, were carrying out their

practice as independent medical practitioners in the hospital. Clause 5 of the aforesaid document has a term/condition which provides as follows:

> *Medical Consultants As Independent Medical Practitioners at GHSB*
>
> *The undersigned agrees and accepts that all medical consultants or healthcare professional who have practicing rights at the Hospital are independent medical practitioners and are not employees of GHSB*. The undersigned also agrees, understands and accepts that it is the sole responsibility of the medical consultants or healthcare professional to obtain the Patient's Informed Consent ...;

(c) Given the fact that second respondent has confirmed that he was carrying out his practice at all material times in the hospital as an independent contractor, and the same was not challenged by appellant, the learned trial judge did not err in dismissing the appellant's claim against the hospital.

[158] The appellant on the other hand submitted as follows:

(a) by virtue of reg 11(4) of the Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006, the second respondent is by statute deemed to be part of the hospital's organisation;

(b) the second respondent's activities, in providing healthcare to patients is integrated with the first respondent's organisation. The first respondent benefited from the services its consultants provided to members of the public. The first respondent should therefore also bear the cost of the harm wrongfully caused by its consultants in the course of them providing healthcare to their patients;

(c) the facts of the present case show a close connection between the second respondent and the hospital and that there is no or insufficient evidence to show that they were 'truly' independent contractors;

(d) in this case, there were no consultancy agreements between the first respondent and the second respondent;

(e) the hospital's terms and conditions of service cannot be said to be sufficient and adequate notice to patients that the hospital is not responsible for the wrongs of its consultants; and

(f) in the absence of a written contract between the two respondents, the first respondent's claim that the second respondent's contractual relationship with the hospital was that of an 'independent contractor' is self-serving and ought to be given lesser weight.

OUR FINDINGS AND ANALYSIS

[159] The two forms of liability ie vicarious liability and the nondelegable duty are in fact conceptually distinct. The distinction between non-delegable duties and vicarious liability was explained in the case of *Dr Kok Choong Seng & Anor v Soo Cheng Lin and another appeal* [2018] 1 MLJ 685; [2017] 10 CLJ 529 (FC).

[160] In *Vincent Manickam s/o David (suing by himself and as administrator of the estate of Catherine Jeya Sellamah, deceased) & Ors v Dr S Hari Rajah & Anor* [2018] 2 MLJ 497; [2017] 8 CLJ 27, the Court of Appeal held as follows:

> [50] From the line of authorities, we are of the view that this considerable question of whether a private *hospital* is *vicariously liable for the negligence of its doctors*, consultants or nurses, that is, the tortfeasor, *is to be determined by investigating and evaluating whether such persons are truly independent contractors or they are, for all intents and purposes, still employees or in special relationships with the hospital*. This evaluation involves mixed questions of fact and law for which we find that the multiple test or common sense approach as the most appropriate test. (Emphasis added.)

[161] Simply put, the court must investigate and evaluate the facts so as to see whether the consultant was truly an independent contractor.

[162] In *Dr Hari Krishnan & Anor v Megat Noor Ishak bin Megat Ibrahim & Anor and another appeal* [2018] 3 MLJ 281; [2018] 3 CLJ 427, the Federal Court held as follows:

> [114] Thus, we would answer the question posed in the hospital's appeal in the negative: *where the doctor is ascertained to be a truly independent contractor in the circumstances, the private hospital cannot be held vicariously liable* for the sole negligence of that doctor. *The true relationship between a private hospital and a doctor practising therein must be determined from the relevant contractual terms and the factual* circumstances of the case. (Emphasis added.)

[163] In the present case, whilst the first respondent claims that the second respondent's contractual relationship with the hospital is that of an 'independent contractor', Norjannah bt Ali ('SD1'), the first respondent's Head of Medical Affairs and Quality, admitted that there was no written contract between the first respondent and the second respondent:

> RES: ... Dr Norjannah, can you confirm that there is no written contract between Gleneagles, the First Respondent and the Second Respondent, Dr Charanjeet?
>
> JANNAH: Yes. I can confirm that there is no written contract.

[164] Further, SD1 agreed under cross-examination that:

A (a) the hospital will coordinate the activities of credentialing and privileging of its consultants;

(b) the appellant's contract is between him and the hospital, and there is no separate contract between the appellant and the consultants;

B (c) the consultants and the second respondent work together with the hospital in providing healthcare to its patients;

(d) the second respondent is considered part of the hospital's organisation;

C (e) the consent form, operation theatre form and checklist for surgery used in the hospital are standardised forms prepared by the hospital in consultation with its consultants;

(f) the terms and conditions of service do not expressly state that the hospital is not liable for the wrongs of the consultant;

D (g) no other information is given to the patient regarding the hospital's liability for its consultants' wrongs;

(h) that the hospital can take action against its consultants for their wrongs;

E (i) that the hospital can and does conduct inquiries into allegations against its consultants; and

(j) that the hospital can terminate the services of consultants following such inquiries if the hospital deems it appropriate.

F **[165]** Premised on the foregoing facts as evidenced at trial, when these facts are taken together, it points to a close connection between the second respondent and the hospital consistent with the first respondent owing a non-delegable duty. We also find that there is insufficient evidence to show that the second respondent was 'truly' an independent contractor. We are of the G view that the hospital's Terms and Conditions of Service cannot be said to be sufficient and adequate notice to patients that the hospital is not responsible for the wrongs of its consultants. Therefore, we find that the hospital was vicariously liable for the negligence of the second respondent.

H NON-DELEGABLE DUTY

[166] The appellant submitted that the non-delegable duty of care applies to the first respondent as the provider of health care. As a provider of healthcare, I the first respondent owed a duty of care, whether or not the second respondent was an independent contractor. Thus, the appellant submitted that the first respondent is in breach of its non-delegable duty of care.

[167] On the other hand, the first respondent submitted that:

(a) the doctrine of a non-delegable duty of care does not and would not apply;

(b) in *Dr Kok Choong Seng & Anor v Soo Cheng Lin and another appeal*, the Federal Court found Dr Kok solely liable for the injuries suffered by the patient;

(c) a non-delegable duty should be imputed only insofar as it would be fair, just and reasonable in the circumstances of each individual case;

(d) based on the facts of this case, it would not be fair, just and reasonable to impute a non-delegable duty on first respondent. It is clear from the evidence adduced during trial, that the hospital did not assign second respondent to attend to the appellant;

(e) the features/factors identified in *Woodland v Essex County Council* [2014] 1 All ER 482 are not present in this case. Thus, the question of a 'non-delegable duty' does not arise; and

(f) first respondent should not be held liable for second respondent's negligence (if any), whether on the basis of 'vicarious liability' or 'non-delegable duty of care'.

[168] In the recent decision of *Siow Ching Yee (suing through his wife and litigation representative, Chau Wai Kin) v Columbia Asia Sdn Bhd* [2024] 3 MLJ 66; [2024] 4 CLJ 173, the Federal Court had by a 4:1 majority decided that the private hospital owed a non-delegable duty of care to the appellant.

[169] Mary Lim FCJ speaking for the majority had referred extensively to the provisions of the Private Healthcare Facilities and Services Act 1998 and its regulations in deciding that the respondent private hospital owed a non-delegable duty of care to the appellant.

[170] In finding that the hospital owed the appellant a non-delegable duty of care, the majority had also decided that the five *Woodland* criteria had been satisfied and that it was not necessary to apply the fair, just and reasonable proviso as decided by the Federal Court in *Dr Kok Choong Seng & Anor v Soo Cheng Lin and another appeal* [2018] 1 MLJ 685.

[171] The majority, had also, by way of obiter, departed from *Dr Kok*'s case and said as follows:

> [81] On the facts, the appellant was admitted to and in the respondent's emergency facilities and treated by its medical officer, prior to being referred to the first and second respondents. The reference to these respondents was by the respondent's own medical officer. These respondents are also part and parcel of the necessary professionals who must be available if the respondent was to provide emergency

A services on a routine basis — see reg 231. More importantly, the negligent act complained of took place during the care and treatment rendered within the respondent's premises using its facilities and services. It did not happen anywhere else; and this appears to have been overlooked in the case of *Dr Kok*. While Mr Soo may have been seen by Dr Kok both before and after the operation at his clinic
B outside Sunway Medical Centre, the operation where the medical negligence and cause of action took place was well within the walls of the hospital.

[172] The issue of a private hospital's non-delegable duty of care to patients was further considered in *Dr Hari Krishnan*. In that case the Federal Court
C found the hospital directly liable for breach of a nondelegable duty of care on the part of the hospital, notwithstanding the hospital's plea of the consultant anaesthetist being an independent contractor. The Federal Court held as follows:

D [134] These facts are materially similar to the facts in *Dr Kok Choong Seng*, wherein the hospital was held not to owe a non-delegable duty to the patient in respect of the operation arranged in a similar manner by the surgeon. The patient's personal choice of the surgeon at his private clinic was held to be a relevant consideration in negotiating an assumption of responsibility by the hospital for the conduct of the operation.

E [135] However, it is at this juncture that the similarities end. As far as the appellant was concerned, *the appellant was dependent on the hospital for the facilities and services indispensable for the second operation*, including anaesthetic services. It was unchallenged that Dr Namazie was requested by the hospital to provide his anaesthetic services at the material time, while the resident consultant anaesthetist
F was on maternity leave. The appellant was left with no choice of anaesthetist for the second operation; in fact, the appellant had initially requested for another anaesthetist — one Dr Manavalan who attended to him in the first operation — but was informed that Dr Manavalan was not available at that time. Dr Namazie was the only anaesthetist on duty on the day of the second operation, and he was involved
G in all operations at the hospital which required general anaesthetics on that day.

[136] It can be inferred from these facts *that the hospital, being the provider of anaesthetic services through Dr Namazie, had assumed a positive duty to the appellant to ensure that reasonable care was taken in the provision of such services by whomever the hospital engaged to do so*. As such, we find that the second feature is satisfied.

H ...

[138] In respect of the fourth feature, the hospital had delegated to Dr Namazie the responsibility to administer doses properly so as to keep the appellant anaesthetised throughout the second operation. *This is an integral part of the positive duty assumed*
I *by the hospital to the appellant, to ensure that care is taken in the provision of anaesthetic services*.

...

[140] Therefore, *applying the principles in Woodland, we conclude that the hospital owed a non-delegable duty to the appellant to ensure that reasonable care was taken in*

the anaesthetic services provided, and we hold the hospital liable for the breach of this duty. (Emphasis added.)

[173] Further, we find that the five *Woodland* criteria are met in this case. The first feature is fulfilled: the appellant was indeed in a vulnerable position and was totally reliant on the respondent for its care and treatment; the second feature was well met by both the statutory framework which puts into place a relationship which deems an assumption of a non-delegable duty of care and also from the factual circumstances.

[174] The appellant did not choose the second respondent to treat him. The appellant had chosen to seek treatment at the first respondent's hospital. The appellant had an antecedent relationship with the first respondent before he was treated by and/or referred to the second respondent. The appellant saw himself as a patient of both the first and second respondents. He had also agreed to various terms and conditions, prepared by the first respondent upon admission to the hospital and such terms and conditions did not come from the second respondent. When he had undergone surgery undertaken by the second respondent at the first respondent's hospital, he did not choose the anaesthetist and he had also paid the first respondent and not the second respondent for the treatment at the hospital.

[175] Furthermore, when the first surgery went wrong, an ultrasound doppler scan was carried out immediately on appellant by the radiologist, Dr Moorthy Sinnasamy, and the same revealed a right popliteal artery pseudoaneurysm and right popliteal vein thrombosis.

[176] As far as the second surgery to repair the popliteal artery injury is concerned, the appellant did not choose Dr Moorthy Sinnasamy to perform the radiology test. Second respondent then referred appellant to Dr Lim Beng Kiat (Consultant Vascular Surgeon), Dr Moorthy Sinnasamy (Consultant Interventional Radiologist) and Dr Mohandas (Consultant Anaesthetist), for co-management. In view of appellant's condition at the material time, Dr Lim Beng Kiat planned an exploratory surgery to repair the popliteal artery for appellant ('the second surgery'). On 8 January 2014, Dr Lim Beng Kiat was assisted by second respondent to perform the second surgery. The popliteal pseudoaneurysm was resolved following the second surgery. An Ultrasound Doppler which was carried out on appellant on 12 January 2014 revealed no deep vein thrombosis. The appellant did not choose Dr Lim Beng Kiat to perform the second surgery. These facts go to show that the negligent act complained of took place during the care and treatment rendered within the first respondent's premises using its facilities and services.

[177] It is also evident that the appellant had no control over how the first

respondent was to perform its function of rendering emergency care and treatment as in this case, the need for the second surgery. The appellant did not have any knowledge whether it would be rendered personally or through employees or some third parties such as the professionals the hospital had engaged and to whom it had delegated the integral function of treatment and care of patients at its emergency services.

[178] In fact, having assumed a positive duty of care to the appellant in respect of emergency services, the first respondent had delegated to Dr Lim Beng Kiat and Dr Moorthy Sinnasamy (Consultant Interventional Radiologist) and Dr Mohandas (Consultant Anaesthetist) and to the second respondent, the performance of its obligations and these persons were indeed performing those delegated functions.

[179] In this regard we refer to the Federal Court case of *Siow Ching Yee* which held as follows:

> [84] ... As for the third and fourth features, it is clearly evident that the appellant had no control over how the respondent was to perform its function of rendering emergency care and treatment; whether it would be rendered personally or through employees or some third parties such as the professionals it had engaged and to whom it had delegated the integral function of treatment and care of patients at its emergency services. In fact, having assumed a positive duty of care to the appellant in respect of emergency services, the respondent had delegated to its medical officer, and to the first and second respondents, the performance of its obligations and these persons were indeed performing those delegated functions at the material time.

[180] As for the fifth feature, it cannot be denied that the second respondent was negligent in the performance of the very function of rendering proper medical care and treatment to the appellant that was assumed by the second respondent.

[181] With all five features satisfied, we find the first respondent had assumed a non-delegable duty of care that it owed personally to the appellant. Following the majority decision of the Federal Court in *Siow Ching Yee (suing through his wife and litigation representative, Chau Wai Kin) v Columbia Asia Sdn Bhd* we find that the first respondent has breached its non-delegable duty of care to the appellant. Thus, the defence of independent contractor does not avail the first respondent.

DECISION

[182] For the reasons stated above, we allow the appeal and set aside the decision of the High Court with costs against the first and second respondents.

[183] The learned trial judge unfortunately did not deliver a decision on quantum. It was the bounden duty of the trial judge to decide on quantum notwithstanding the dismissal of the claim on liability (see *Multar v Lim Kim Chet & Anor* [1982] 1 MLJ 184; [1982] CLJ 107 (FC)).

[184] This court thus direct that the trial judge undertakes this duty to assess damages. The case is remitted to the High Court at Kuala Lumpur for assessment of damages.

[185] Cost of the appeal here and below to the appellant in the sum of RM60,000 against the first respondent and RM120,000 against the second respondent subject to the allocator.

Azimah Omar JCA (delivering dissenting judgment of the court):

INTRODUCTION

[186] The appeal before us is a claim for medical negligence regarding a rare complication which had occurred following a surgical procedure of arthroscopy of the appellant's knee which was conducted under the direct care and supervision of one Dr Charanjeet Singh who runs his own private clinic (as Consultant Orthopaedic & Trauma Surgeon) ('the second respondent') within a private hospital known as Gleneagles Hospital Kuala Lumpur ('the first respondent'). The appellant's causes of action can, inter alia, be identified as follows:

(a) negligence (for *failure to properly treat* (in the conduct of the surgical procedure) and *failure to properly warn and advice*) against the second respondent; and

(b) the first respondent's *vicarious liability* for the second respondent's negligence and/or the first respondent's *breach of non-delegable duty of care*.

[187] We first heard the appeal on 13 March 2024 and thereafter this appeal was adjourned for decision on 19 June 2024. My learned brother Justice Kamaludin bin Md Said JCA and my learned sister Justice Supang Lian JCA had decided (as majority decision) that there were merits in the appellant's appeal and thereby allowed the appellant's appeal against the decision of the High Court with costs. Contrary to the majority decision, I am however of the view that there were no merits in the appellant's appeal against the decision of the High Court. Therefore, I am of the view that the appellant's appeal should be dismissed with costs be awarded in favour of the respondents. I shall now proceed to deliberate on the grounds of my dissenting judgment.

[188] As I have mentioned in para [186] of this dissenting judgment, the present appeal arose from a medical negligence claim filed by the appellant in the Kuala Lumpur High Court for an injury he had sustained as consequence of a surgical procedure (arthroscopy of his knee) which was conducted on the appellant by the second respondent. The factum of the injury was undisputed. What was laboriously contended was instead the issue of whether or not the injury was sufficiently rare and unforeseeable to the extent that the advent of the injury did not fall below the second respondent's standard of duty of care. Closely related to this issue was the issue of whether or not the nature of the injury was sufficiently rare and remote to the extent that it should not be expected of the second respondent (or fall within the second respondent's standard of duty of care) to warn or advise the appellant of the risk of such injury prior to proceeding with the surgical procedure.

[189] Specific to the first respondent, the appellant and the first respondent also strenuously contended on the issue of vicarious liability and non-delegable duty of care allegedly personally owed by the first respondent-hospital.

[190] The learned High Court judge ('learned judge') on 13 September 2022 had dismissed the appellant's claims against both respondents. The learned judge had found that the nature of the injury occasioned was so rare and unforeseeable to the extent that the advent or occurrence of the injury does not necessarily denote that the second respondent was negligent (or had breached his standard of duty of care to treat and diagnose). The learned judge also found that the subject injury was so rare it ought not be within the second respondent's standard of duty of care to warn or advise the appellant of the rare injury prior to the surgical procedure. The learned judge also found that any prior advice or warning of the rare injury would still be immaterial to the appellant as the appellant's decision to proceed with the surgical procedure (to avoid a far more invasive total hip replacement surgery) would not be dissuaded even if the appellant was warned or advised of the rare injury prior to the surgical procedure.

[191] As the appellant's case for negligence against the second respondent had already been thwarted, the learned judge then proceeded to dismiss the appellant's claim for vicarious liability and breach of non-delegable duty against the first respondent.

[192] Dissatisfied with the learned judge's decision, the appellant filed the appeal before us to challenge the correctness of the learned judge's decision. For a proper appreciation of the contentions above, it is crucial that we first understand the facts underlying this case.

FACTS OF THE CASE

[193] Tan Sri Datuk Seri Mohd Hussein ('appellant') suffers from persistent right knee pain. In pursuit of alleviating himself from the pain (and upon the appellant's friend's personal recommendation) the appellant had personally opted and chose to seek medical consultation from the second respondent.

[194] Following the appellant's friend's recommendation, the appellant had first presented himself to the second respondent at the second respondent's outpatient clinic situated within the first respondent's hospital on 4 March 2013. Several outpatient clinic consultations ensued in which the second respondent had conducted examinations and numerous medical scans (x-ray and MRI scan) on the appellant's knee. Throughout the series of consultations, the second respondent had always maintained his medical advice that:

(a) the most ideal treatment to alleviate the pain would by the most invasive surgical procedure being a total knee replacement surgery ('TKR'); and

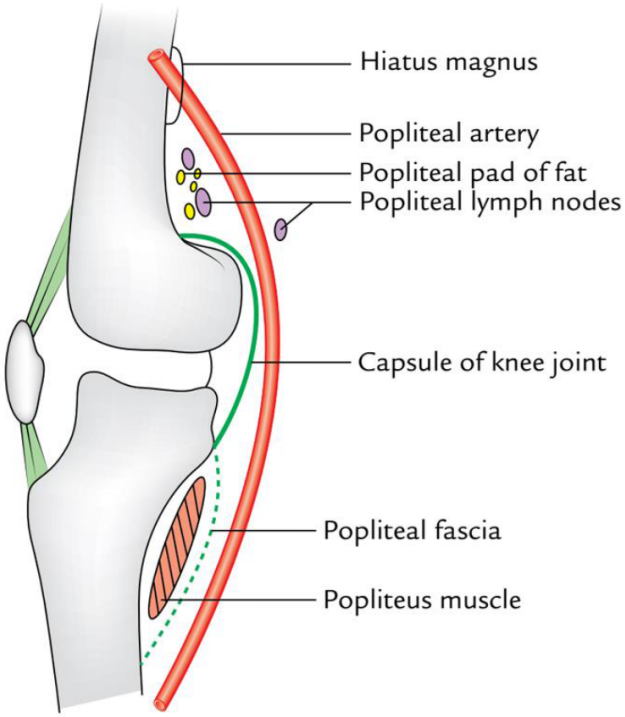
(b) alternatively, if the appellant was not keen to undergo the most invasive TKR surgery, the appellant can also opt for minimally invasive procedures to symptomatically 'minimise' the pain but not alleviating the root cause of the pain altogether.

[195] The appellant throughout his consultation and relationship with the second respondent had always maintained a preference over less invasive procedures and an aversion against the more invasive TKR procedure. Thus, on 6 March 2013 the appellant was first treated with a lubricant injection administered by the appellant's chosen consultant, the second respondent. Just five days thereafter on 11 March 2013, the appellant again consulted the second respondent complaining of the same pain. At this juncture, the second respondent then advised the appellant to opt for the TKR. Alternatively, and less ideally, the appellant was also informed of the option of a lesser invasive arthroscopy procedure to repair the knee meniscus and cartilage. Following the same inclination for minimally invasive procedures, the appellant opted for and consented to a right knee arthroscopy.

[196] In furtherance of the arthroscopy opted for, the second respondent on 27 December 2013 conducted the right knee arthroscopy upon the appellant ('impugned surgery'). Typical of many surgeries, the appellant had to undergo post-operative treatments and procedures following the impugned surgery prior to being discharged. At the time of these post-operative procedures, the appellant noticed a blue-black mark on his right knee and experienced excruciating pains during physiotherapy.

[197] In response to the appellant's post-operative pains, an investigation

into the pains were carried out. An ultrasound undertaken by the first respondent's radiologist was indicative of a popliteal artery tear or damage of the right knee. This was further identified to be vascular injuries of the right popliteal artery pseudoaneurysm and right popliteal vein thrombosis via multiple ultrasound doppler tests conducted upon the appellant. In layman terms, the tests revealed that an injury was occasioned upon the vein that runs behind the knee capsule where the surgical procedure was conducted:



[198] Thereafter, the appellant was referred to a Consultant Vascular Surgeon within the first respondent (Dr Lim Beng Kiat) who had then conducted an evacuation of haemotoma and repair of the popliteal artery ('surgical repairs') on 8 January 2014. The surgical repairs were successful and the appellant gradually recovered. The appellant remained warded for post-operative treatments for another six days after which the appellant was discharged without event on 14 January 2014.

[199] In view of the above, the appellant thereafter commenced an action in negligence to claim for damages (both general and special) for all the costs incurred, pain and suffering endured due to the injury occasioned upon his popliteal artery against both the respondents.

BEFORE THE HIGH COURT

[200] As mentioned earlier, the factum of injury to the popliteal artery was at all times undisputed. Nonetheless, as much as the High Court was sympathetic to the appellant's predicament, the law of negligence does not stand solely on the proof or existence of an injury. It must also stand with all other requisite elements of breach of standard of duty of care, causation, and foreseeability (or remoteness) of damage. And it was the latter elements of breach of standard of duty of care and foreseeability which were heavily contested before the High Court.

[201] The stages of any negligence claim (inclusive of medical negligence) sequentially involves:

(a) establishment of *DUTY OF CARE* between the claimant and the tortfeasor;

(b) specific to any nature of negligence, upon establishing a duty of care, the court then *has to identify the gauge (or threshold) in which the STANDARD OF CARE* can be measured. In the field of medical negligence, there are many case laws which prescribe different tests and thresholds to different aspects of medicine (such as treatment, diagnosis, and advice or warning);

(c) upon identifying the standard or threshold, then the facts of the case shall be tested against that standard to identify *whether or not the tortfeasor (in this case the doctor) had conducted his practice in manners beyond or below the threshold* expected of him;

(d) then the court must look into the nature of damage or injury itself and ask the question whether or not the injury suffered related to or foreseeably caused by the tortfeasor's breach of his duty/standard of care (*element of foreseeability/remoteness of damages or causation*); and

(e) if all of the above makes a definite case of negligence, then the court should proceed to determine the appropriate measure or quantum of damages to be awarded to the claimant.

[202] But the facts in this appeal presented a unique circumstance where the respondents contended that the injury would have occurred despite there has not been any breach of standard of duty of care. In other words, though there has been an injury occasioned during the impugned surgery:

(a) the injury was not caused by any negligence but instead was caused by unforeseeable and rare turn of events which led to the injury despite the second respondent acting well within the threshold of his professional standard of duty of care; or in other words

(b) the injury would have still occurred notwithstanding that the second respondent had conducted his practice well within the threshold of his professional standard of duty of care.

[203] Thus, this appeal is not a typical case where negligence can automatically be inferred from the mere existence or occurrence of unintended injury occasioned during the impugned surgery. The High Court had to properly endeavour to identify whether or not the injury was still bound to happen even if the second respondent had not been negligent.

[204] The first dissonance lies on the theorised caused of the popliteal artery injury. Parties have furnished their respective expert reports as well as expert witnesses to testify during trial. In essence, there were two competing theories as to the manner the injury had occurred:

(a) the appellant's expert testified that the injury to the artery was cause by *use of excessive force* in which the second respondent had negligently applied the wrong measure of force in handling the blunt surgical instruments to the extent that the instruments had pierced right through many layers of tissues of the knee capsule and ultimately pierced the popliteal artery behind the knee capsule ('excessive force theory'); and

(b) the respondents' experts testified that the injury was occasioned because of an *EXCEPTIONALLY RARE* condition in which the branching of the appellant's blood vessels 'entangled' the appellant's popliteal artery. In usual and common circumstances, when these blood vessels were shaved or tugged by the shaver (instrument used to shave and 'vacuum' tissue debris out for debridement of the joint) the blood vessels just collapse without event. But in the appellant's exceptionally rare branching of the blood vessels, the blood vessels when shaved had unfortunately 'avulsed' or pulled on the popliteal artery which caused the artery to be damaged ('avulsion injury theory').

[205] The expert witnesses from either sides were at odds as to the cause of the injury. But *ALL EXPERTS WERE IN AGREEMENT that an avulsion injury (caused by unusual branching of the blood vessels) WAS EXCEPTIONALLY RARE* in cases of a knee arthroscopy such as the impugned surgery.

[206] The case was at a stalemate as far as the two butting theories go. Thus, the High Court had to examine if there were any other logical facts or evidence which could identify the more probable cause of injury from the two:

(a) excessive force theory: The appellant had only supposed that excessive force was applied to the extent that the blunt instruments pierced through layers of tissues and finally reach the popliteal artery situated behind the knee capsule. Apart from this bare supposition, *the appellant*

DID NOT OFFER any other supporting evidence or logical observations to further support the excessive force theory; A

(b) avulsion injury theory: The second respondent *indeed furnished supporting evidence and logical observations* to support the avulsion injury theory: B

(i) the scope and shaver used in the impugned surgery were *BLUNT INSTRUMENTS* which by design do not possess any piercing or sharp qualities to enable the blunt instruments to pierce through multiple layers of tissues to reach the popliteal artery far behind the knee capsule; and C

(ii) there were *NO OTHER INDICATION OR EVIDENCE OF SURROUNDING TISSUE DAMAGE* in and around the knee capsule to indicate such a forceful piercing by the blunt instruments through many layers of tissues of the knee capsule. D

[207] In determining this first dissonance, the learned judge had insightfully preferred the avulsion injury theory simply because the respondents were able to offer further logical observations and insights which adds further legitimacy and degree of reasonable probability to the avulsion injury theory. The learned judge astutely identified and appreciated that *there were no reports or evidence* of other tissue tears or piercing in the surrounding knee capsule to support the appellant's excessive force theory: E

> [73] Having measured a number of factors in considering expert evidence, their qualifications and expertise including their scientific approaches, I find that the explanation by SD3 is acceptable with logical analysis, who had explained in detail and in a very comprehensive manner that practically it was not possible to exert excessive force using the blunt shaver. On the other hand, I am unable to accept the SP2 reasoning on how the popliteal artery injury occurred since the instruments used for the first surgery were blunt instruments, which were impossible to penetrate to the back knee. In my view the penetration was simply not possible and it is doubtful for such a blunt instrument to penetrate the knee capsule and reach the back of the knee without signs of severe damage and bleeding during the first surgery. F G
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> [74] There was no description by SP2 as to the carelessness on part of the second defendant in performing the first surgery. In my view, the assumption of carelessness alone as the only explanation that has resulted the injury cannot be accepted and devoid of logical deduction. The possibility of avulsion injury was shared by all the experts in this case which dispels the conception that the injury could only have occurred if there was carelessness. H I

(paras 73 and 74 of the learned judge's grounds of judgment).

[208] Upon identifying the most probable cause of the arterial injury, the

learned judge proceeded to identify the standard of care of the second respondent's duty of care owed to the appellant. Given both sides' expert's unanimous agreement that an avulsion injury was exceptionally rare and uncommon, the learned judge concluded that the occurrence of the avulsion injury was not due to any negligence of the second respondent and instead was due to the exceptionally rare instance of the branching of the appellant's blood vessels entangling/tugging the popliteal artery during the impugned surgery. Thus, the learned judge had determined the second dissonance as to the standard of the duty of care owed by the second respondent to the appellant.

[209] The third dissonance was regarding the other aspect of medicine which is the duty of warning, advice, or proper information owed by the second respondent to the appellant. This third dissonance was separated into two determinations:

(a) whether or not the second respondent's warning of the risk of 'bleeding' encompasses the risk of an avulsion injury upon the artery behind the knee capsule; and

(b) whether or not the second respondent owed the standard of duty of care to specifically inform and warn the appellant of the risk of an avulsion injury prior to the conduct of the impugned surgery.

[210] The learned judge found that risk of bleeding would cover or encompass an avulsion injury to the artery as the tugging of the popliteal artery would lead to the popliteal artery to bleed:

> [54] The second defendant testified that he had prior to the first surgery warned the plaintiff of the risks of 'bleeding, infection, blood clot, meaning deep vein thrombosis' could occur. The risk of injury is to the surrounding arteries, including the popliteal artery would necessarily include 'bleeding' as stated in the consent form. The consent form states as follows as regards the surgical complications that the plaintiff was advised of:
>
> > Nature and purposes of the procedure/surgery*, the benefit and risks of the operation or procedure, the possibilities of complications 1 and the alternatives to this operation or procedure and their risks and benefits as stated below have been explained to the patient/spouse/parent/guardian/next-of-kin of the patient*
> >
> > *Bleeding
> >
> > *Infection
> >
> > *Others
> >
> > *Deep vein thrombosis

(para 54 of the learned judge's grounds of judgment).

[211] The learned judge upon considering the *Rogers v Whitakers* test (as to the duty of care to warn or advice) had found that the instance of avulsion injury was sufficiently rare that: A

(a) the second respondent cannot be expected to warn the appellant of every and all risk (especially rare risks) before the appellant's consent to the impugned surgery; and B

(b) a warning of risk of an avulsion injury was immaterial to the appellant as such warning was very unlikely to deter the appellant's main and constant preference to opt for lesser invasive procedures (instead of the more invasive TKR surgery): C

> [60] I took note that the expert opinion of SD3 which state that the injury to the vessels is a risk factor in an operation of the knee and the bleeding can occur following the injury to the vessels. This position was also supported by SD3 who testified that when the blood vessels are shaved or pulled, usually these blood vessels collapse and there is no injury. It is only very occasionally happened because of some abnormality of the branches which avulsion injury can happen to anyone. With the explanation of SD3, I am satisfied to accept that the risk of a popliteal artery injury encompassed by the warning of risk of bleeding and other surgical complications, as advised to the plaintiff and documented in the consent form of the first surgery. To my mind, any person would have necessarily understood that bleeding would occur following an injury to the blood vessels or arteries. Further, even if the second defendant had warned the plaintiff of the specific risk of popliteal artery injury, the plaintiff would still have undertaken the first surgery because he was reluctant to undergo total knee replacement at the material time and he had no other choice to alleviate his knee pain, other than the first surgery. D E F
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> [61] It is well-established that the court (and not a body of respected medical practitioners) will decide whether a patient has been properly advised of the risks associated with a proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it (see *Rogers v Whitaker* (1992) 109 ALR 625). G
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> [62] In relation to the popliteal artery injury, all the expert witnesses confirmed that the injury is a rare complication. In fact, SD3 also clearly explained and illustrated the reasoning behind the popliteal artery injury being a rare complication. Given that the popliteal artery injury is a rare complication, the second defendant did not therefore owe the plaintiff the duty to advise of such a risk. With that, the second defendant had sufficiently warned the plaintiff of the risk of injury to the popliteal artery. Therefore, I find that there was no failure on the part of the second defendant to discharge his duty to properly advice, inform and warn the plaintiff on the risk of the first surgery. H I

(paras 60, 61 and 62 of the learned judge's grounds of judgment).

[212] Thus, the learned judge had found that the second respondent had not fallen below the standard of care to diagnose, treat, advice, and warn the appellant. It followed that the learned judge had not proceeded to determine on the issues of vicarious liability and non-delegable duty of care seeing that the core case of negligence against the second respondent had already fallen.

[213] Dissatisfied with the learned judge's decision, the appellant filed the present appeal before us.

THE APPEAL BEFORE US

[214] Upon my perusal of the appellant's memorandum of appeal, records of appeal, and the parties' respective written submissions, I am of the view that this appeal can be appropriately be disposed of by determining the following issues:

(a) issue 1: whether the learned judge was correct to find that the second respondent had not gone below the standard of duty of care to diagnose and treat (*Bolam*'s test) despite the undisputed occurrence of the arterial injury;

(b) issue 2: whether the learned judge was correct to find that the second respondent's duty and standard of care does not cover the extent of specifically warning or advising the appellant on the exceptionally rare risk of avulsion of the popliteal artery;

(c) issue 3: whether the learned judge was correct to find that the second respondent had not gone below the standard of care to warn and advice (*Roger v Whitaker*'s test) despite the undisputed occurrence of the arterial injury; and

(d) issue 4: whether the first respondent had breached its non-delegable duty of care owed to the appellant.

PRELIMINARY ISSUES AS TO PLEADINGS

[215] Before I proceed onto the four issues listed above, I will first determine the appellant's preliminary contention against the raising of the avulsion injury theory alleging that the avulsion injury theory was never pleaded within the second respondent's statement of defence.

[216] Although it is peculiar to note that the appellant's own pleaded facts as to the 'piercing' of the popliteal artery *also never pleaded the excessive force theory*. In the same manner, the second respondent had only pleaded that the

occurrence of the piercing was not due to any negligence of the second respondent. *NEITHER PARTY PLEADED THEIR RESPECTIVE SCIENTIFIC THEORIES underlying the base facts of their respective pleadings*.

[217] On the issue of pleadings, the appellant's contention is akin to putting the cart before the cattle. The entire debate as to the manner or method of how the injury was occasioned would be a supremely intricate matter of scientific evidence which only later during trial should be led by the medical experts. It need be reminded that the pleadings are primarily the court instrument of the litigants and not the expert witnesses (especially medical experts) who will later furnish their respective insights during trial vide their expert report and expert testimonies before the court. *These are all matters of evidence*.

[218] Of course, the manner and method in which the injury was occasioned are facts, but these are facts which by its probative nature, are evidence which can prove or disprove the appellant's allegations of fault and liability, and prove or disprove the respondents' contention of innocence.

[219] To expect the entire narration of the experts' views to be embedded within the pleading itself would only unnecessarily complicate the pleading and inundate the court with matters of evidence, which the parties would already be afforded the opportunity to contend at long lengths later during the stages of furnishing their respective expert reports and oral examinations of their respective experts. There was no reason at all to put the cart ahead (these matters of evidence) of the cattle (due process of the court).

[220] In fact, as rightfully highlighted by the second respondent, even the appellant's own pleadings had not pleaded the manner and method in which the injury was occasioned. The appellant only pleaded that the popliteal artery was 'pierced' but not at all the manner in which the piercing was allegedly caused. It was not readily pleaded by the appellant that the piercing was caused by excessive force. Thus, if I were to agree with the appellant's contention, then the appellant himself should be barred from contending the excessive force theory.

[221] Therefore, the appellant's contention on the pleading shall fail in accordance to the appellant's own logic and supposition. The appellant's nature and extent of pleadings as to the 'piercing' of the popliteal artery was no different to (and no more extensive than) the second respondent's pleadings.

Issue 1: Whether the learned judge was correct to find that the second respondent had not gone below the standard of duty of care to diagnose and treat (Bolam's test) despite the undisputed occurrence of the arterial injury

[222] I must preface my judgment that the injury occasioned against the appellant was nothing short of a tragedy and I deeply sympathise with the inconvenience, pain, and agony the appellant had suffered due to the injury occasioned upon his right knee popliteal artery. Nevertheless, I am also minded that the court is an arena of holistic fairness where cases are adjudicated upon its facts, the prevailing law at the time, and not merely on physical or emotional sentiments.

[223] I am minded that the field of medicine (alike many professional fields) deals with extremely minimal margin of error and high stakes. But at the same time the field of medicine also does not operate in absolutes. Although minimal, there can and must be a reasonable and acceptable margin of error. For the field of medicine is heralded by mankind and mankind is neither perfect nor infallible. There must be a balance to be struck in the medicolegal field so as to exert enough authority as to ensure that medical practitioners conduct their practice to the best of their expertise but at the same time to allow enough room so as to allow medical practitioners to perform their professional duties with confidence and ease of mind.

[224] I am of the view that the advent of the arterial injury was not the expected or ideal intended outcome of the arthroscopy (impugned injury) conducted on the appellant's right knee. No parties within the appeal would deny the occurrence of this unfortunate accident. But an accident in its true nature and meaning, is not automatically indicative of negligence. An accident is simply that event which occurred unintentionally. An accident indeed can occur unintentionally because of negligence (or acts below the threshold of standard of duty of care). At the same time accidents can occur because of unforeseeable or rare complications which at times may arise even after practicing well within the accepted threshold of standard of duty of care.

[225] The learned judge at the trial court was faced with this very precarious determination. And I can clearly identify that the learned judge was properly minded of the evidence and the determinations that the learned judge had to deliberate and ultimately adjudicate on. The scale of justice must either tilt to the side of the excessive force theory (proving negligence) or to the side of the avulsion injury theory (disproving negligence).

[226] It must be reminded that the scope and role of the appellate court is not to re-litigate matters already decided at trial. The appellate court should only examine whether or not there were any manifest errors as to the trial court's decision or the trial court's decision-making process. That be the case, I must necessarily examine the learned judge's reasons for preferring the avulsion injury theory.

[227] The test of determining the standard of care applied in Malaysia is still the *Bolam* test. The *Bolam* test simply entails that the standard of care owed by a doctor shall be the standard of practice that was 'accepted as proper' by a group or body of doctors who are experts in the relevant aspect or field of medicine. If the impugned doctor had acted within the threshold of this 'accepted practice' then that doctor would not be considered negligent despite the occurrence or advent of unintended injury. The *Bolam* test has been applied locally by the Federal Court in the case of *Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors* [2017] 5 MLJ 438; [2017] 8 CLJ 605 in the standard of care for the duty of diagnosis and treatment.

[228] If the case for the excessive force theory was proven, then naturally the finding of negligence would ensue as the negligent act would clearly glean from the exertion of 'excessive force' beyond the acceptable practice to the extent that the blunt instruments had pierced through numerous layers of tissues until it pierced the popliteal artery behind the entire knee capsule.

[229] On the contrary, if the case for the avulsion injury theory was proven, then no finding of negligence can ensue as all the expert witnesses were in agreement that:

(a) an avulsion of the artery was exceptionally rare in the instance of an arthroscopy;

(b) an avulsion of the artery is caused by the rare branching of the blood vessels which would inadvertently avulse or tug onto the popliteal artery; and

(c) an avulsion of the artery *can still occur even if there were no instance of carelessness (or conduct below the acceptable practice)*.

[230] With the two competing theories in mind, the learned judge must appropriately determine which of the two competing theories proved to be more probable than not. Thus, the learned judge must look further into the facts to identify if there are other surrounding facts and information which would edge one theory ahead of the other.

[231] I agree with the basis and analysis which the learned judge had considered in reaching upon the learned judge's preference to the avulsion injury theory. Apart from the supposition of the 'mechanism' of the excessive force theory the appellant had not provided any other logical evidence or facts which could lend more credence upon the excessive force theory. On the extreme contrary, the second respondent had supposed three logical facts and evidence which would lend more credibility as to the avulsion injury theory:

(a) firstly, if indeed there was exertion of excessive force to the extent of

cutting through layers of tissues and muscles of the knee capsule until the artery, then there must be evidence of other surrounding tissue damage or injury indicative of such piercing;

(b) secondly, there was no evidence within any medical report that reported any other tissue damage surrounding the knee capsule which would positive the indication of cutting or piercing of the blunt instruments through the knee capsule; and

(c) thirdly, the instruments used were blunt instruments (camera scope and shaver) which by design do not possess any cutting or piercing features or qualities.

[232] Thus, as there were no other logical or evidential facts that could contra the above, then it was well within the learned judge's good judgment to prefer the avulsion injury theory over the excessive force theory.

[233] In fact, it would be remiss if I do not refer to the England and Wales Court of Appeal decision in *Nadollek v Queen's Medical Centre* [2002] EWCA Civ 1617 which was in pari materia with the present appeal. *Nadollek*'s case involved a similar case of an unforeseeable and unavoidable arterial avulsion causing a thrombosis (which is exactly on point with the appeal before us). There the Court of Appeal had dismissed the patient's application to appeal the dismissal of his negligence claim as the Court of Appeal had concluded that *an avulsion injury was rare and was one of the rare instance of accidents which may occur WITHOUT THE ELEMENT OF CARELESSNESS OR NEGLIGENCE*:

> [14] ... What is perhaps more to the point is the concession that *the risk of thrombosis fell within the risk of further avulsion* — that is to say, that the risk which had to be assessed for continuing or discontinuing was the global risk of a further arterial disaster, whatever its precise nature. This helped the claimant's case over a potentially awkward legal hurdle. *But it DID NOT SEE HIM OVER THE FACTUAL HURDLE OF PROVING A DEPARTURE by Professor Mulholland FROM A STANDARD OF CARE set by reference to current professional practice and judgment*.
>
> [15] Mr Nadollek is understandably perplexed at the outcome. An operation which should have put him back on his feet has left him in a wheelchair for life. It is a natural reaction to say that someone must have blundered. *But medicine is not an exact science and accidents happen*. Some undoubtedly do happen because a doctor has fallen short of the standard of professionalism which is required of him or her. *Others — the AVULSION OF THE ARTERIES during the present operation is an example — just happen and ARE NOBODY'S FAULT*. The same is true of the judgments which have to be made in the course of difficult surgery which is going wrong. It may well be with hindsight that Mr Mulholland should not have continued; this is not the same thing as saying that his election to do so was negligent. The judge has explained why with care, although not in terms that

> Mr Nadollek accepts; but we are bound to say, with regret, that there is no detectable error of law in his approach and no misappreciation of the evidence capable of undermining his conclusions. (Emphasis added.)

[234] As an aside, the appellant also loosely had contended an argument that 'rarity' does not negate foreseeability. This argument, the appellant had loosely staked to prove two contentions:

(a) it matters not that the complication or incident was exceptionally rare so long as the end result (injury) was foreseeable to the nature of negligence that had occurred; and

(b) the second respondent still bears the duty to specifically warn or advise the appellant to the exceptionally rare risk of popliteal artery injury, as the end result (injury) was foreseeable to the nature of negligence that had occurred.

[235] I will deal with the issue of the second respondent's duty to warn or advise in a separate heading below. I will first deal with the appellant's attempt to prove negligence by proving foreseeability above rarity. The folly in this supposition is glaring from the very construction of the contention. This is because foreseeability of damage alone cannot prove negligence. I will explain this in a plain and simple example:

> X accidentally drove his car to collide against the car driven by Y. Y foreseeably suffers damage to his person and to his property (his car). In a normal and common circumstance of driving, X had been negligent as X had failed to observe a safe distance from Y's car. However, if for instance by a *rare and unforeseeable circumstance* that X's car was unable to stop or decelerate because of a rare computer and mechanical error in the car's throttle systems, X would have still driven his car to collide with Y's car *EVEN IF X had already attempted to decelerate and observe a safe driving distance within the accepted practice of driving.*

[236] There are two aspects and realms rarity or foreseeability at play here. *First* being the *rarity and foreseeability of culpability as to a negligent act*. *Second* being the *rarity and foreseeability between the injury suffered and the cause of the injury*. Thus, the *first inference* that can be drawn from the example is that, X had not been negligent as it was rare and unforeseeable of him to identify that his car's computer and mechanical throttle systems were in error. The *second inference* is that it was foreseeable that Y would suffer damages to his person and property as a result of the accident or collision.

[237] Is it sufficient for Y to only prove the second inference to succeed a claim for negligence against X? I certainly do not believe so. Proving the proximity of the Y's damage to the collision does not automatically prove that X had been negligent. And this is exactly the reason that the appellant's

A contention must fail. Of course it was well within foreseeability that the appellant would suffer physical and emotional pain from the avulsion injury. But proving this proximity between the damages to the avulsion injury does not at all prove the element of negligence. It only proves proximity of damages in the aspect of remoteness of damages.

B

[238] I will further unravel the folly in the appellant's argument by addressing the appellant's reliance on the case *Hepworth v Kerr* [1995] 6 Med LR 139. In *Hepworth v Kerr*, although the English Court had dealt with the instance of a rare complication of a *SPINAL stroke*, it was also an undisputed C fact that the complication of a *CEREBRAL stroke* was well within foreseeability to be caused by the anaesthesiologist's negligence. There the English Court dealt with a *singular foreseen consequence of a STROKE*. In such a case, it was reasonable for the English court to positive the finding of negligence, as the D minor difference between a *SPINAL* or *CEREBRAL* stroke does not affect the factum (or change the nature) of the *foreseeable STROKE*.

[239] Similarly, the appellant's reliance on the case of *Wiszniewski v Central Manchester Health Authority* [1996] 7 Med LR 248 was also unfortunately E misconceived. There the English Court dealt with the unfortunate instance where a baby was negligently born vaginally (when the circumstances would require the baby to be born via caesarean section) causing the baby to suffer hypoxia. The case there involved the exceptionally rare instance of a 'true knot' of the umbilical cord. But the rarity of the true knot did not at all deter the F culpability of the doctor's negligence in his delay and failure to timeously attend to the patient-claimant. In *Wiszniewski*, although a true knot of the umbilical cord was exceptionally rare, it was still within the realm of foreseeability to avoid hypoxia if only the doctor did not fall below the accepted standard of practice to timeously attend to and investigate the patient. On the G contrary, the rare advent of avulsion injury in the present appeal was still unforeseeable and unavoidable even if the second respondent had already conducted the impugned surgery well within the accepted standard of practice.

H **[240]** More so, the appellant's reliance and reference to the case of *Emeh v Kensington and Chelsea and Westminster Area Health Authority and others [1979 E No 446]* [1985] QB 1012 was taken wildly out of context. Although the court there found negligent liability to the *remote risk* of the birth of a child with congenital abnormalities, the court had found so in relation to the I foreseeability of the damages (in the conception and birth of an *UNWANTED CHILD*) to the negligent act (of a *FAILED STERILISATION SURGERY* of the birth mother). Again, this case was decided on the issue of remoteness of damages and not on the issue of rarity or foreseeability in the context of a doctor's standard of duty of care. Of course it was foreseeable that the

conception of an unwanted child was the glaringly foreseeable consequence of a failed sterilisation surgery.

[241] The rarity of the congenital disease was not at all the issue there. Instead the issue was simply regarding a failed family planning surgery, which foreseeably would cause the mother to unintentionally conceive a child. The negligence (failed sterilisation surgery) matches the nature of damages (conception of unwanted child). The issue dealt with in the present appeal was totally on a different plane and context of foreseeability (being foreseeability in the context of culpability of negligence or determining the standard of duty of care). In the appeal before us, the rarity and foreseeability of the avulsion injury goes far deeper so as to affect the identification or setting of the threshold of the standard of duty of care owed by the second respondent. Not merely matching the nature of damages suffered to the avulsion injury which have occurred.

[242] Again, I must reiterate that the cases relied upon by the appellant were mainly cases dealing with remoteness of damage and not cases which dealt with rare medical complications or circumstances in the aspect of the threshold or the standard of duty of care to diagnose and treat. The facts of the present appeal were vastly different in that the issue of rarity and foreseeability of the avulsion injury was relevant in the context of the culpability of the negligent act itself (and not merely the remoteness of damages between the avulsion injury and the nature of injury suffered by the appellant).

[243] The non-invasive nature of the arthroscopy would already denote the rarity and foreseeability of an injury to the deep popliteal artery. It was because it was minimally invasive (as experts have testified) that the popliteal artery behind the knee capsule was not presentable during the arthroscopy. The nature of a minimally invasive arthroscopy itself would mean to minimise invasion and exploration through layers of tissues. That would in turn also mean lesser visibility and reach of the deeper tissues and arteries behind the knee capsule. Thus, a unique or rare branching of the blood vessels to the popliteal artery certainly cannot be seen and was unforeseeable in the context of an arthroscopy.

[244] In view of all the above under this heading, I answer *issue 1 in the POSITIVE*. The learned judge was indeed correct to find that the second respondent had not gone below the standard of duty of care despite the undisputed occurrence of the arterial avulsion injury.

Issue 2: Whether the learned judge was correct to find that the second respondent's duty of standard of care does not cover the extent of specifically warning or advising the appellant on the exceptionally rare risk of avulsion of the popliteal artery

[245] It should naturally entail from my positive answer in issue 1 that issue 2 would also be answered positively that the standard of duty of care to warn or advice owed by the second respondent *DOES NOT* encompass the warning or advising of the specific risk of avulsion injury. In plain logical terms, since the avulsion injury was sufficiently rare and unforeseeable to be avoided by the second respondent, it shall logically follow that the avulsion injury was sufficiently rare and unforeseeable to expect the second respondent to warn the appellant of it before the impugned surgery. Nonetheless, merely for the sake of completeness I will endeavour to address this issue 2 at full length.

[246] As rightfully appreciated by the learned judge, the standard of duty in the context of *warning and advising of risks* is different than that of the *Bolam* test (for treatment and diagnosis). It has long been a celebrated medicolegal principle that the appropriate test to determine the standard of duty of care to warn or advise would be the '*Rogers v Whitaker* test' propounded by the Australian High Court in the landmark case of *Rogers v Whitaker* (1992) 175 CLR 479. The *Rogers v Whitaker* test determines the materiality of a risk and whether or not such risk was sufficiently material to be informed to the patient before undergoing any given procedures. Thus, unlike *Bolam* test which examines the threshold from the viewpoint of medical men, the *Rogers v Whitaker* test instead examines the threshold *FROM THE VIEWPOINT OF THE PATIENT*.

[247] The Australian High Court propounded that a *risk is material* if:

(a) in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or

(b) if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.

[248] But in the specific realm of rare and unforeseeable complications, *the rare and unforeseeable nature of the risk ALSO AFFECTS THE MATERIALITY OF THAT RISK*. There is also a long line of precedents which had to draw the line to what should be reasonably expected of a doctor to warn *as it would be unreasonable to expect a doctor to warn about all and every conceivable risks to every procedure*.

[249] Certainty and exactitude is ideal but medicine is logically and reasonably not always certain and not always exact. Thus, any given risk might also be *IMMATERIAL* when such risk was *rare and unforeseeable or minimal*. In any line of professional work there are an infinite number of risks that a professional must weave and manoeuvre through. It would be unreasonable to

expect such professional to advise or warn his client on all infinite extent of risks or pitfalls. Even in the realm of litigation practice, counsels lose cases even if they had exercised utmost diligence in advising and advocating his client's case.

[250] Should a litigation loss must necessarily denote negligent conduct of a case? I certainly do not believe so. Why must the medicolegal realm be the exception? It certainly should not be an exception. The same manner a lawyer ought not be expected to warn his client of all nature of risks in the theatre of law, a doctor ought not to be expected to warn his patient of every and all nature of risks in the operation theatre. Neither the court nor the operation theatre is a perfect machine that is immune to the infinite exigencies that organically and dynamically shape and govern the human society in any given era.

[251] It should suffice that the doctor warns and advises his patients of material risks which are:

(a) material in the context of the *Rogers v Whitaker* (in that the patient might attach some significance to that warning in culminating his decision to proceed with the procedure or otherwise); and

(b) material in the context of foreseeability and remoteness of a risk to the nature of the medical procedure that would be undertaken by the doctor upon his patient.

[252] The second respondent's postulation was *NOT BASELESS* or without legal and judicious support either. I agree with the second respondent's reliance on the case of *Dr Ismail Abdullah v Poh Hui Lin (administrator for the estate of Tan Amoi @ Ong Ah Mauy, deceased)* [2009] 2 MLJ 599 in which the High Court had dealt with the same issue of standard of duty to warn a patient in the context of a risk that was rare and minimal:

> [22] Now, *applying the principles of law in Rogers v Whitaker* which I have adverted to earlier, it is my judgment that the learned sessions court judge had failed to follow the principle that *only material risks, and NOT MINIMAL RISKS* of injury arising out of the open cholecystectomy need to be disclosed to the plaintiff or the deceased. This is a serious misdirection which has occasioned a failure of justice which is of itself a sufficient ground to justify interference of this court.
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> [36] ... The *risks of ARDS* and pancreatitis accruing as a result of the operation *WERE VERY RARE AND MINIMAL. In my view there was NO DUTY TO INFORM the deceased of the VERY RARE RISK* of such a thing happening. The deceased must only be informed by the first defendant of the material risks of the proposed operation.
>
> ...

A [38] In other words, the principle underlying in *both Bolam and Rogers v Whitaker is that a duty to warn a patient of the risk* arising out of proposed treatment or operation arises only if the risk is a *material risk*, and *NOT A MINIMAL RISK* and that whether a risk is material or not is a question which often requires expert evidence, which is a useful guide for courts.

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[253] The salutary words above were certainly instructive to me in ascertaining the threshold and extent of standard of duty to warn that was expected of the second respondent. It is plain logic that the second respondent as a doctor cannot be expected to inundate the appellant with a tremendously C long list of all conceivable risks involved however minimal or rare the risks might be before the second respondent could be deemed to have fulfilled his standard of duty of care to warn.

D **[254]** The same judicious wisdom was also shared by the District Court of West Australia in the case of *Christou v King Edward Memorial and Princess Margaret Hospitals Board of Management* [2007] WADC 44:

[180] ... *I see no need for the plaintiff to have been warned*, in the circumstances of her case, as to the *SMALL RISK OF PERFORATION OF THE JEJUNUM OR SMALL* E *BOWEL*. She would have been unlikely to differentiate, in any event, between the small and the large bowel. In the circumstances of the plaintiff's case there is no basis for concluding that Dr Cohen, or Dr Kumar for that matter, should have been aware that the plaintiff, if warned of the risk of perforation of the jejunum would have been likely to attach significance to it.

F [181] I find that *even if the plaintiff had been warned of the risk of damage to the small bowel as opposed to the large bowel she would still have undertaken the surgery* because she saw a hysterectomy as being a sure means of relief for what she regarded as extremely troublesome and debilitating problems. In my view her claim arising out of the alleged failure to warn of the material risks must fail. (Emphasis added.)

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[255] Even, assuming I am wrong with my analysis into the standard of duty to warn in the context of rare and minimal risks, I am of the view that the classical *Rogers v Whitaker* test would also work in favour of the second respondent's case. The threshold question in *Rogers v Whitaker* is whether (in H the patient's viewpoint) the patient would attach any significance to the information had he be warned of the risk. If the patient would attach such significance that would affect his decision prior to consenting to the procedure, then that risk shall be a material risk that must be warned by the doctor.

I **[256]** It is my considered view that the learned judge had correctly appreciated that the appellant's unwavering and consistent preference to avoid fully invasive surgery such as the more ideal TKR. The appellant had instead opted for the arthroscopy despite knowing that the joint debridement (clean up) will not fully remedy his pains. The appellant remains headstrong to opt for

the lesser invasive surgery. Knowing of the appellant's unshakeable preference, it was more probable than not that the appellant would NOT change his mind to proceed with the arthroscopy even if the appellant was warned of the risk of an avulsion injury to the popliteal artery.

[257] In fact, it would be reasonable to infer that the appellant would be more incentivised to proceed with the lesser invasive arthroscopy after being aware that such a minimally invasive procedure would already pose such risk against the deep artery behind the knee capsule, what more a full-on invasive surgery such as a TKR.

[258] In view of all the above findings under this heading, I answer *issue 2 in the POSITIVE*. The learned judge was indeed correct to find that the second respondent's duty of standard of care to warn does not cover the extent of specifically warning or advising the appellant on the exceptionally rare risk of avulsion of the popliteal artery.

[259] For the sake of completeness, we also find that the appellant's postulation on the issue of foreseeability over rarity (loosely in the context of duty to warn) was sorely misplaced. As we have identified earlier in this judgment, the appellant had unfortunately taken some cases on remoteness of damages out of the precedents' proper context. Similarly, the cases of *Hepworth v Kerr*, *Wiszniewski v Central Manchester Health Authority*, *Emeh v Kensington and Chelsea and Westminster Area Health Authority*, and *Warren v Scruttons* all *were not cases relevant to the issue of the standard of duty of care to warn in the context of rare and minimal risks*.

Issue 3: Whether the learned judge was correct to find that the second respondent had not gone below the standard of duty of care to warn and advice (Roger v Whitaker's test) despite the undisputed occurrence of the arterial injury

[260] I have already deliberated at length on identifying the threshold or standard of duty of care to warn in issue 2 above. Considering my positive answer to issue 2, it must necessarily follow that *issue 3 be answered in the POSITIVE*. The learned judge was correct to find that the second respondent had not gone below the standard of duty of care to warn and advice. We decide so on the following grounds:

(a) since the applicable standard of duty of care to warn in this case does not encompass the duty to specifically warn the appellant of the risk of an avulsion injury, then the second respondent would have satisfied his standard of duty of care to warn notwithstanding whether or not the second respondent had in fact specifically warned the appellant of the rare and minimal risk of an avulsion injury;

(b) thus, since it was not incumbent upon the second respondent to specifically warn the appellant of the rare and minimal risk of an avulsion injury, the entire issue of whether or not the warning of 'bleeding' would also encompass the avulsion injury *is already moot*; and

(c) thus, there is no necessity for us to go at greater lengths to determine the 'bleeding warning' issue which is already moot.

Issue 4: Whether the first respondent had breached its non-delegable duty of care owed to the appellant

[261] I shall not delve into the appellant's cause of action for vicarious liability against the first respondent considering I have already agreed and affirmed the learned judge's decision to dismiss the appellant's negligence claim against the second respondent, simply because there shall not be any negligence for the first respondent to be vicariously liable to.

[262] Nonetheless, I am still beckoned to examine the law of non-delegable duty of care and its application in the present appeal. The learned judge had not made any findings as to this issue on the grounds that the core allegation of negligence against the second respondent-consultant was already dispelled. However, I am minded that the concept of non-delegable duty of care is a very new creature within the realm of tort at least within the Malaysian landscape of law of negligence.

[263] The intriguing feature of this concept is that a non-delegable duty of care seems to override or bridge the trite and celebrated concepts in contract law and in the law of negligence (such as contract law on independent contractors (contract for service) and law of negligence on vicarious liability). The reason I say so is simply because establishing of this new tort in a given case would 'negate' the traditional demarcation between an employer (the hospital) and the hospital's independent contractors. The net effect of establishing a breach of non-delegable duty of care is that the employer (hospital) would still remain liable to the negligence of its independent contractor (which in a classic case of vicarious liability would not have been possible).

[264] But in reality, a non-delegable duty of care is not at all an extension of vicarious liability. In fact, the true context and essence of a non-delegable duty of care is that such non-delegable duty is *independent of the liability of an independent contractor to the negligence* and is *personally owed by the employer (hospital) to its patient*.

[265] Much literature and precedent had poured from numerous commonwealth jurisdictions including our own. But it is most ideal for me to comprehend and appreciate this new feature in tort law in the simplest of

terminology so as to provide much clarity as to what a 'non-delegable duty' truly is. And to achieve this I must first examine the landmark UK Supreme Court ('UKSC') decision in *Woodland v Essex County Council* [2014] 1 All ER 482.

[266] In *Woodland*'s case, the UKSC had to determine whether or not a *SCHOOL* can escape from liability over the negligence of *independent contractors* (who were not employees of the school or the local education authority) in *supervising the pupils' swimming lessons during school hours* which led to the injury of a student (the claimant).

[267] The UKSC was clear that the appeal before them had very little to do with vicarious liability as the UKSC was more concerned of the school's or local education authority's non-delegable duty of care it owed to its students. The reason why the UKSC endeavoured beyond the typical confines of vicarious liability was because the appeal dealt with *A BASE AND CORE DUTY OF A SCHOOL to educate its students in a safe environment*. Otherwise, if a school was able to relinquish itself off of such base and core duty to ensure the safety of its students, then the school would have betrayed the most basic essence of a school as a safe and secure environment for the education of its students.

> [4] The issue on this appeal is, however*, nothing to do with vicarious liability*, except in the sense that it only arises because there is none. On the footing that the local authority was not vicariously liable for the negligence of Mrs Stopford, Ms Burlinson or Ms Maxwell, the question is what was the scope of the authority's duty to pupils in its care. Was it a duty to take reasonable care in the performance of the functions entrusted to it, so far as it performed those functions itself, through its own employees? Or was it a duty to procure that reasonable care was taken in their performance by whomever it might get to perform them? On either view, *any liability of the education authority for breach of it is personal, not vicarious*. (Emphasis added.)

[268] The UKSC further observed that a non-delegable duty of care, if established, would depart from the usual treatment of vicarious liability, as the law would impose upon the defendant not only the duty to ensure its own careful performance, *but also the careful performance of its delegates (independent contractors)*:

> [5] This is because, as Cory J observed, delivering the judgment of the majority in the Supreme Court of *Canada in Lewis (guardian ad litem of) v British Columbia* [1997] 3 SCR 1145 at para 17, a common law duty of care 'does not usually demand compliance with a specific obligation. It is only when an act is undertaken by a party that a general duty arises to perform the act with reasonable care'. The expression *'non-delegable duty' has become the conventional way of describing those cases* in which the ordinary principle is displaced and the *duty extends* beyond being careful, *to procuring the careful performance of work delegated to others*. (Emphasis added.)

[269] Nonetheless, the burning question and determination in cases of non-delegable duty of care had always been *what is the extent or what should be within the threshold of such base and core duty that cannot be delegated*. The reason why this question was oft-debated in these cases was because the courts cannot escape from the inevitable reality that the manner and method a body or organisation works, and the nature of work of a body or organisation can be so diverse and complex that the determination or demarcation of the threshold of that base or core duty is not as clear-cut. The UKSC was minded of this difficulty as well:

> [22] The main problem about this area of the law is to prevent the exception from eating up the rule. Non-delegable duties of care are inconsistent with the fault-based principles on which the law of negligence is based, and are therefore exceptional. The *difference between an ordinary duty of care and a non-delegable duty* must therefore *BE MORE THAN A QUESTION OF DEGREE*. (Emphasis added.)

[270] To conjure a form of consistency and uniformity in dealing with drawing the line between an ordinary duty of care and non-delegable duty of care, the UKSC then propounded the *Woodland test*. But rather than just appreciating the *Woodland* test as a list of conjunctive criteria, *the Woodland test is more accurately an examination of PROCESS and PROCEDURES underlying the subject duty of care litigated upon*.

[271] It is from the examination of the process and procedures leading up to the impugned negligent act that the courts have been able to ascertain where does ordinary duty of care (and vicarious liability) ends, and where non-delegable duty of care extends from. Now, the *Woodland* test and examination upon the process and procedures goes as follows:

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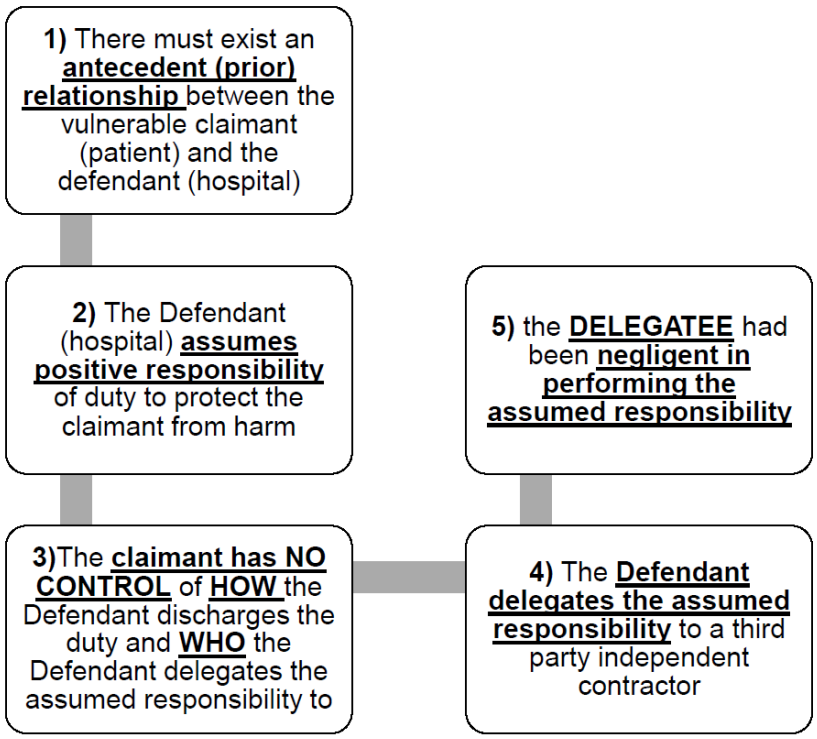
1) There must exist an antecedent (prior) relationship between the vulnerable claimant (patient) and the defendant (hospital)
2) The Defendant (hospital) assumes positive responsibility of duty to protect the claimant from harm
3)The claimant has NO CONTROL of HOW the Defendant discharges the duty and WHO the Defendant delegates the assumed responsibility to
4) The Defendant delegates the assumed responsibility to a third party independent contractor
5) the DELEGATEE had been negligent in performing the assumed responsibility

[272] Looking at the illustration above, the *Woodland* test akin to running a relay race. The patient intends to win the relay race (in other words to heal and recover from his afflictions). The patient starts the race holding the baton. The patient then passes or entrusts the baton to the second runner, the hospital (which establishes antecedent relationship between patient and hospital). The second runner (hospital) accepts the baton and continues the second leg of the relay (assumption of positive responsibility win the race (to treat the patient)). The second runner (hospital) then passed and entrusted the baton to the third runner (delegation of the second runner's prior assumed responsibility). The third runner accepts the baton and ran the final leg of the relay. The patient had no control as to who the hospital intends to pass the baton to, and as to how the third runner (independent contractor) is going to run the final leg of the race (to discharge the assumed responsibility to care for the patient).

[273] The 'relay race' analogy was exactly how the recent local precedents at the Federal Court level had examined and identified the threshold of a non-delegable duty of care. The Federal Court had focused on a given case's facts on how and between whom the 'baton' was passed or entrusted. It was pertinent and critical that the 'baton' was first passed from the patient *DIRECTLY to the hospital* for the hospital to first assume the positive

responsibility of care and *thereafter process and care after the patient (by its own internal process, mechanism, and administration)* before the hospital can thereafter pass the baton (delegate) its assumed responsibility to the hospital's independent contractor. Only if this chain of passing of assumed responsibility was established, that the duty of the independent contractor (third party delegate) becomes the non-delegable duty of the hospital.

[274] Thus in *Woodland*'s case, the UKSC had found that although the swimming lessons were delegated to the independent contractors, the students and the parents already shared a prior or antecedent relationship with the school. The parents sent their children to the school in reliance of the school's expertise to educate the students in a safe environment. The school assumed the positive responsibility of educating the students in a safe environment. The swimming lessons took place during school hours when the students were in the care of the school. The independent contractors as delegates, had only performed the school's prior assumed responsibility (which therefore was a non-delegable duty:

> *Held – (2)* ... The authority allowed to schools over children, for their education, conferred on schools a significant degree of control. When the school's own control was delegated to someone else for the purpose of performing part of the *school's own educational function*, it was wholly reasonable that the school should be answerable for the careful exercise of its control by the delegate. *Parents were required by law to entrust their child to a school*; they did so in reliance on the school's ability to look after the child, and generally had *no knowledge of or influence over the arrangements that the school might make to delegate specialised functions*, or the basis on which the school did so, or the competence of the delegates, all of which were *matters about which only the school was in a position to satisfy itself*. The liability of a school was not open-ended; *schools would be liable for the negligence of independent contractors ONLY IF AND SO FAR AS THEY WERE PERFORMING FUNCTIONS WHICH THE SCHOOL HAD ASSUMED FOR ITSELF A DUTY TO PERFORM*, and where control over the child had been delegated by the school. (Emphasis added.)

[275] Thus, it can be clearly seen that the elements of antecedent (prior) relationship and the assumption of positive responsibility are critical in establishing a non-delegable duty of care. The same focus and sentiment was shared by our own Federal Court in *Dr Kok Choong Seng & Anor v Soo Cheng Lin and another appeal* [2018] 1 MLJ 685.

[276] Similar to the present appeal, the patient in *Soo Cheng Lin* shared an antecedent relationship *directly with the independent contractor (doctor) NOT THE HOSPITAL*. This was because the patient there also directly and intentionally chose and pursued consultation with the doctor. Soo Cheng Lin initially directly consulted the doctor in the doctor's private clinic. Soo Cheng Lin then was admitted into the hospital following the doctor's referral to further proceed with the intended surgery upon Soo Cheng Lin. Thus, the full

chain of delegation in *Woodlands* was not complete as the patient had from the outset directly passed the baton to (consulted) the doctor and not the hospital. Thus, there was no antecedent relationship between the patient and the hospital for the hospital to thereafter assume the positive duty of care to treat the patient:

> *Held – (1)* ... However, the *facts in this case point against the existence of such an antecedent relationship*. From the circumstances surrounding Soo's engagement of the doctor and admission to the hospital, it can be inferred that *Soo reasonably expected the operation to be conducted by the doctor with due care, wherever the doctor referred him to do so*. In respect of the conduct of the operation by the doctor, the *hospital had not assumed a positive duty to protect the plaintiff from injury*. Thus, the second feature in the *Woodland* case formulation was not satisfied on the facts, in that the *hospital had not assumed a positive duty* in respect of the conduct of the operation.
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> (2) In addition to the second feature in the *Woodland* case not being satisfied on the facts, the questions of how the hospital chose to perform the duty (the third feature), *the hospital's delegation of an integral part of that duty* (the fourth feature), and the delegatee's negligence in the performance of the duty (the fifth feature) *did not arise*. (Emphasis added.)

[277] The same sentiment was very recently echoed by the Federal Court in *Siow Ching Yee (suing through his wife and litigation representative, Chau Wai Kin) v Columbia Asia Sdn Bhd* [2024] 3 MLJ 66. In *Siow Ching Yee*'s case, the whole of *Woodland*'s five features chain of delegation was established as the patient there first established an antecedent relationship with the hospital and not the consultant doctor who performed an emergency surgery onto the patient. The consultant was an independent contractor, but the consultant had no prior relations with the patient. The patient was the *HOSPITAL'S PATIENT FIRST* (whereby the hospital assumed the positive responsibility to provide the patient with emergency care). Upon the hospital's assumption of positive duty of care (when the hospital admitted and warded the patient through its internal rendering of emergency services), *only then the hospital delegated and referred the patient's case (the assumed responsibility) to the consultant-independent contractor.*

[278] Furthermore, when the patient was first admitted and treated as the hospital's patient first, the patient had no choice or control as to the actual doctors who will care for the patient and as to how the doctors will perform the hospital's assumed responsibility:

> *Held – (7)* ...This court found that the five-features test propounded in *Woodland v Essex County Council* [2014] 1 All ER 482; [2013] UKSC 66 ('Woodland') for the imposition of a non-delegable duty of care had been satisfied: (1) the appellant was in a vulnerable position and was totally reliant on the respondent for his care

A and treatment, more so when he was admitted to its emergency services; (2) *the feature of 'antecedent relationship' was well met* by both the statutory framework which put into place a relationship which *deemed an assumption of a non-delegable duty of care* and *by the fact that the appellant WAS FIRST TREATED BY THE respondent'S MEDICAL OFFICER IN THE EMERGENCY DEPARTMENT before the officer referred him to D1 and D2*. D2's negligent act took place within the respondent's premises, and not anywhere else, whilst the appellant was being treated using the respondent's facilities and services; (3) *the appellant had NO CONTROL OVER HOW HE WOULD BE TREATED AND BY WHOM — whether by the respondent's employees or other professionals it had engaged and to whom it had delegated* the integral function of treatment and care; (4) *having assumed a positive duty of care to the appellant in respect of emergency services, the respondent had delegated to its medical officer and to D1 and D2*, the performance of its obligations and those persons did in fact perform the delegated functions at the material time; and (5) D2 had negligently performed the very function of rendering proper emergency care and treatment to the appellant that was assumed by the respondent but delegated to D2 by the respondent. Given that all the five features in *Woodland* were satisfied, the defence of independent contractor was not legally and factually sustainable and ought to have been rejected by the courts below (see paras 222–223 & 226–227). (Emphasis added.)

[279] The Federal Court also applied the same ratio decidendi in the case of *Dr Hari Krishnan & Anor v Megat Noor Ishak bin Megat Ibrahim & Anor and another appeal* [2018] 3 MLJ 281. *Megat*'s case in fact dealt with a case which entailed both circumstances where a *PATIENT-CHOSEN* ophthalmologist's duty of care was ruled to *NOT BE the hospital's non-delegable duty of care while a HOSPITAL-ASSIGNED* anaesthetist's duty of care was ruled *TO BE the hospital's non-delegable duty of care*.

[280] In *Megat*'s case, the patient had a direct antecedent relationship with the ophthalmologist in which the patient had first directly consulted the ophthalmologist in the ophthalmologist's private clinic. The patient had consulted the ophthalmologist upon the personal referral of another doctor. Only upon prior private consultation with the ophthalmologist that the patient thereafter was referred and admitted to the hospital for the purposes of surgery. In these circumstances regarding the ophthalmologist, the Federal Court found that the *Woodland*'s test was not satisfied.

[281] On the contrary, the patient had personally requested for another specific anaesthetist (who was at that material time was not available). Thus, *the hospital designated and assigned another anaesthetist within its rank* to undertake the administration of anaesthesia for the patient's surgery. In view of this designation and assignment by the hospital, the Federal Court found that the crucial elements of assuming positive responsibility and delegation by the hospital in the *Woodland*'s test had been satisfied.

[282] It is exceedingly clear that the Federal Court had consistently paid much concern, attention, and consideration upon the manner and facts which makes up the 'chain' of delegation in determining whether or not an independent contractor's duty of care shall be also deemed to be the hospital's non-delegable duty of care.

[283] Applying all of the above principles and precedents, it is also exceedingly clear that the facts and circumstances of the present appeal glaringly do not satisfy the five features of the *Woodland*'s test (chain of delegation):

(a) the appellant was the second respondent's patient first, before the appellant undergone the arthroscopy at the first respondent's hospital;

(b) thus, there was no antecedent (prior) relationship between the appellant and the first respondent's hospital. There was instead antecedent relationship directly between the appellant and the second respondent;

(c) the second respondent as the appellant's chosen surgeon (not the first respondent hospital) had directly assumed positive responsibility to treat the appellant;

(d) the appellant had full control and freedom to choose the second respondent to be his chosen surgeon to undertake the arthroscopy;

(e) the second respondent was not assigned or delegated with the assumed positive responsibility by the first respondent-hospital; and

(f) the second respondent *HAD NOT BEEN NEGLIGENT*.

[284] In view of all my findings and deliberation above in this part, I hereby answer the *fourth issue in the NEGATIVE* in that *the first respondent HAD NOT breached its non-delegable duty of care owed to the appellant*.

MY DECISIONS AND ORDERS

[285] All of the above considered, I find that there were *NO MERITS* to this appeal. I hereby *DISMISS* the appellant's appeal and accordingly affirm the learned judge's decision for dismissing the appellant's claims against the first and second respondents.

[286] Considering that I am of the view of dismissing the appellant's appeal with costs, thus the order for costs should be as follows:

The appellant should be ordered to pay costs of RM50,000 to the second respondent, and costs of RM25,000 to the first respondent. Both order for costs should be subject to allocator.

A *Appeal allowed; High Court's decision set aside; and case remitted back to the trial court for assessment of damages.*

Reported by Ashok Kumar

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